

Southampton County School Board
21308 Plank Road
P.O. Box 96
Courtland, VA 23837

Family and Medical Leave Packet

**Southampton County School Board
Request For Family and Medical Leave**

(submit at least 30 days prior to planned event)

Employee Name _____ Date of Request _____

Social Security # _____ Position _____

_____ **Request for Family Leave**

Date(s) _____ No. of Days _____

Relationship to Employee*

_____ Son/Daughter* Age _____

Date of Birth _____

Date of Adoption _____

Date of Foster Care _____

_____ **Request for Medical Leave**

Date(s) _____ No. of Days _____

_____ Individual Employee

_____ Son/Daughter* _____ Under 18
_____ 18 years of age or older and incapable of self-care because of mental or physical disability.

_____ Spouse

_____ Parent*

Sick Leave Bank _____ Yes _____ No

Note: A Medical Certificate must be submitted on a form provided by the Superintendent with 15 days of this request. The Superintendent may require, at the School Board's expense, a second opinion of a Provider designated or approved by the Superintendent. The current State Sick Leave policy shall apply for any paid leave.

Request Approved _____

Request Disapproved _____

Employee Signature

Superintendent or Designee

To be submitted in duplicate

***see Southampton County Public Schools Regulations for definitions.**

**SOUTHAMPTON COUNTY SCHOOL BOARD
MEDICAL CERTIFICATION**

Patient's Name _____ Employee's Name _____

Patient's Relationship to Employee _____ Attending Physician _____

Date of Visit _____ Phone # _____

Address _____

Eligible employees may request up to 12 weeks of medical leave for a serious health condition or to care for a spouse, son, daughter or parent with a serious health condition.

A child 18 years of age or older qualifies if he/she is incapable of self-care because of mental or physical disability. Incapable of "self-care" means the individual requires active assistance or supervision to provide daily self-care in several activities of daily living.

The Division Superintendent may require, at the School Board's expense, a second opinion of a provider designated or approved by the Superintendent concerning any information in this certification. If the second opinion differs from the original, a second opinion may be required. Subsequent certification may be required on a reasonable basis.

Please check below the condition which apply:

The term "serious health condition" means an illness, injury, impairment, or physical or mental condition that involves:

- _____ Any period of incapacity or treatment in connection with or consequent to inpatient care in a hospital, hospice, or residential medical care facility.

- _____ Any period of incapacity requiring absence from work, school, or other regular daily activities, of more than three calendar days that also involves continuing treatment by a health care provider; or continuing treatment by a health care provider for a chronic or long-term health condition that is incurable or so serious that, if not treated, would likely result in a period of incapacity of more than three calendar days; or for prenatal care.

The term "continuing treatment by a health care provider" means one or more of the following:

- _____ the employee or family member is treated two or more times for the injury or illness by a health care provider or by a provider of health care services under orders of, or referral by, a health care provider, or the employee or family member is treated by a health care provider on at least one occasion which results in a regimen of continuing treatment with the supervision of the health care provider.

- _____ the employee or family member is under the continuing supervision of a health care provider due to a serious long-term or chronic condition or disability which cannot be cured.

NOTE: Voluntary or cosmetic treatments which are not medically necessary are not serious health conditions, unless inpatient hospital care is required.

Expected duration of serious health condition _____

Comments or further explanation: _____

Physician's Signature

Date

**SOUTHAMPTON COUNTY SCHOOL BOARD
MEDICAL CERTIFICATION TO RESUME WORK**

Employee/Patient Name _____

Attending Physician _____ Phone _____

Address _____

The above named patient is able to resume work on ____/____/____.

The nature of his/her condition is not a health threat to students or staff.

Additional Comments:

Physicians Signature

Date