



**HASTINGS  
PUBLIC SCHOOLS**  
Assuring the essential.  
Expanding the possible.

## **Work Session**

Thursday, July 8, 2021 @ 6:00 PM Central  
Middle School Multi-Purpose Room, 201 North Marian Road, Hastings, NE 68901

1. Roll Call -
2. Announcement - Jim Boeve -
3. Welcome to HEA reps and guests - Jim Boeve -
4. Review Board Norms/Goal - Jim Boeve -
5. 2021-2022 Budget Preparation report - Jeff Schneider -
6. ESSER Funding update - Jeff Schneider -
7. HPS Safe Return to Learn Plan - Jeff Schneider -
8. Accreditation Final Report - Jeff Schneider -
9. Approve Purchase of Land near Morton School building - Trent Kelly -
10. Approve Revised Policy 504.18 Anti-Discrimination and 402.01 Equal Opportunity Employment - Jeff Schneider -

11. Approve Revised Attachments for Policy 404.10 Family and Medical Leave, All Employees - Jeff Schneider -

12. Approve First Reading of New Policy 706.025 Internal Controls - Jeff Schneider -

13. Reaffirm District Policies and Rules - Jeff Schneider -

14. Student Information System proposal - Trent Kelly, Kristy Kennedy, Terry Julian -

15. Add 6.0 FTE SEBL Paraeducator positions - David Essink -

16. \*Consent Agenda - David Essink -

17. Reminders - Jim Boeve -

18. Adjournment - Jim Boeve -

**\*Closed Session:** If, during the course of the meeting, discussion of any item on the agenda should be held in a closed meeting, the board will conduct a closed meeting in accordance with the Nebraska Open Meetings Law.

**\*\*Sequence of Agenda:** The sequence of agenda topics is subject to change at the discretion of the board. Please arrive at the beginning of the meeting.

**\*\*\*Action Item:** The board reserves the right to take action on an item listed on the board agenda.

Students, staff, families and community will collaborate to maximize readiness for our student's college/career and citizenship. We will increase the rigor and relevance of each student's learning experience while meeting their academic and well-being needs.

# Hastings Public Schools

## Board of Education Norms

We will work to achieve consensus while valuing differences of opinion both within our Board and when considering the input of others.

We will conduct meetings and business in a manner that is fair and professional.

We will strive to ensure our decisions are congruent with the mission, vision, and strategic plan for the District.

Each member will be committed to the School Board process by attending meetings, being on time, coming prepared, adhering to the agenda (the President of the Board may adjust the order of the agenda to allow the fullest participation of the available members of the Board upon the request of a Board Member), *referencing Robert's Rules of Order*, and participating to their full potential.

We will gather the necessary data; seek expertise from within and outside of our District; and attempt to hear from any parent, student, or other community member in order to make wise decisions that reflect all stakeholders.

We will regularly and intentionally communicate with one another, the administration, faculty, staff, students, community, and the press to ensure information is shared openly and in a relevant, timely and appropriate manner.

We will also maintain confidentiality when necessary.

We will serve as advocates for K-12 public education within our community, as well as within the state of Nebraska.

We will recognize that, as community leaders, we will adhere to the character standards that are the core of our school: respect, responsibility, compassion, and honesty.

***Our collective and fundamental purpose is to assure all students acquire the knowledge, skills, and behaviors essential to be successful individuals and responsible citizens.***

General Fund Receipts

	16-17	17-18	18-19	19-20 Act	20-21 est	21-22 Est
local	11,877,346	12,623,848	12,891,631	14,171,449	14,000,000	14,600,000
state aid	19,933,715	20,731,503	19,588,944	19,556,527	19,896,331	21,491,019
sped	3,066,091	3,083,461	3,221,688	3,489,321	3,400,000	3,400,000
state	1,927,501	1,970,024	2,210,884	2,619,497	2,000,000	2,400,000
Fed	2,526,214	1,864,240	2,478,645	2,466,701	3,000,000	6,000,000
	39,330,867	40,273,076	40,391,792	42,303,495	42,296,331	47,891,019

HPS ESSER Funds  
July 8, 2021

1. ESSER Funding Totals:
  - A. ESSER I Total: \$700,000
  - B. ESSER II Total: \$3,000,000
  - C. ESSER III Total: \$6,700,000

**Total ESSER Funding = \$10,400,000** to be used over the 20-21, 21-22, 22-23, & 23-24 school years. Estimated General Fund Expenditures during this time span is \$170,000,000. **The ESSER funds will make up approximately 6% if our overall expenditures during this time frame.**

2. How were the allocations figured?  
**Based on student need!**
3. NEED PUBLIC INPUT!
  - A. Will lay out a plan on the website and ask for feedback
  - B. Have a meeting scheduled in August with a committee from the Chamber.
  - C. Meeting with GIPS and KPS on July 22<sup>nd</sup> to discuss possibilities
  - D. August agenda item subject to public comment
4. Three Big Ideas for HPS Admin as we strategically plan for the use of these funds.
  - A. Serve students and help them overcome learning loss (7.0 FTE and focus on reading)
  - B. Be strategic enough to make sure these positions are funded beyond the 23-24 school year. (Transportation needs, curriculum)
  - C. Maintain the technology and operations portion of the District in a responsible manner (tech infrastructure, HVAC and window replacement to improve air quality, clean procedures)

<b>ESSER I</b>	
Maintain the operation	\$287,100
Technology	\$373,309
PPE	46,260
Cleaning/Sanatizing supplies	5188
Total Grant	\$711,857
Timeline	Completed

<b>ESSER II</b>	20-21	21-22	22-23	Total
Class size redcuton teachers*		403,000	415,000	818000
Cleaning/sanitizing supplies*	57,000			57,000
Technology*	237,000			237,000
Learning Loss positions (7.0 FTE)		605,000	621,000	1226000
Tech Support*		280,000	286,000	566000
HVAC/Air Quality Improvements		70,000		70000
Indirect Costs		20,000	20,000	40,000
				3014000



## **Hastings Public Schools Safe Return to Learn Plan**

The Hastings Public Schools will ensure continuity of services, including but not limited to services to address student's academic needs and students' and staff social emotional, mental health, and other needs, which may include student health and food services.

HPS was able to accomplish this in the 2020-21 school year by using a variety of strategies, many of which are listed below. Counselors, Teachers, School Administrators, and School Psychologist were instrumental in the mental health accommodations for both students and staff members. Some of the other strategies/procedures were:

1. Face Coverings:
  - A. Required for students and staff in 20-21 until May 16<sup>th</sup>
  - B. Recommended in all HPS buildings since 5-16-21
  
2. Social Distancing:
  - A. Used alternate lunch procedures and spaces to allow as much as possible.
  - B. Attempted to use outdoor classrooms as much as possible
  
3. Hand washing and respiratory etiquette.
  - A. Scheduled extra time for hand washing and sanitizing.
  - B. Made hand sanitizer available in almost every room in the district
  
4. Cleaning and maintaining healthy facilities.
  - A. Altered cleaning routines to schedule more time to clean surfaces more often such as door handles, desks, etc
  - B. Using enhanced HVAC products to improve the air quality.
  
5. Contact tracing in combination with isolation and quarantine.

HPS will continue to work with local health officials in determining the need for isolation and quarantine for both students and staff members.
  
6. Diagnostic and screening testing.
  - A. HPS will continue to ask parents to screen students at home prior to bringing them to school.
  - B. HPS will continue to ask staff members to self-screen before reporting for duty.
  
7. Efforts to Provide Vaccinations to school community  
HPS already has and will continue to offer our facilities to be used as vaccination sites for students with parental consent as well as for staff members.

8. Appropriate accommodations for children with disabilities with respect to health/safety policies  
Each student with a disability will have accommodations to meet their health and safety needs.
  
9. Coordination with State and local health officials.  
HPS will continue to meet with and coordinate with State and local health officials and will be prepared to change operating procedures should the need arise. We will also continue to monitor the guidance given by the CDC.

#### “Ensuring Continuity of Services”

Hastings Public Schools will continue to ensure continuity of services, including but not limited to services to address students’ academic needs and students’ and staff’s social, emotional, mental health, and other needs, which may include student health and food services.

#### “Public Comment Requirements”

Hastings Public Schools sought public comment/feedback during multiple board meetings during the 20-21 school year as well as via phone calls and emails to the Administration. There will be continued opportunities for public feedback during the 21-22 school year as well (the district shall seek public comment for each six-month revision or revisions due to significant changes to CDC guidance). Anyone wishing to provide immediate feedback can do so by contacting Jeff Schneider, Superintendent, at 402-461-7511 or at [jeff.schneider@hpstigers.org](mailto:jeff.schneider@hpstigers.org).



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0 10 20 40  
SCALE IN FEET

BATEMAN STREET

16' UTILITY EASEMENT

20'

q

9 STALLS

9 STALLS

6' WALK

58.5'±

21.5'

15'

21.5'

6'

9/16

15'

85'

BALTIMORE AVENUE

## **ANTI-DISCRIMINATION, ANTI-HARASSMENT, AND ANTI-RETALIATION**

### 1. Elimination of Discrimination

The Hastings Public Schools hereby gives this statement of compliance and intends to comply with all state and federal laws prohibiting discrimination. This school district intends to take any necessary measures to assure compliance with such laws against any prohibited form of discrimination.

The Hastings Public Schools does not illegally and unjustly discriminate on the basis of sex, disability, race, color, religion, veteran status, national or ethnic origin, marital status, pregnancy, childbirth or related medical condition, sexual orientation or gender identity, or other protected status in its programs and activities and provides equal access to the Boy Scouts and other designated youth groups. Reasonable accommodations will be provided to employees with disabilities and to those who are pregnant, have given birth, or have a related medical condition, as required by law. The following persons have been designated as “Coordinators” to handle inquiries regarding the non-discrimination policies:

Students: Director of Special Education, 1924 West A Street, Hastings, Nebraska, 68901, 402-461-7516

Employees and Others: Director of Human Resources and Operations, 1924 West A Street, Hastings, Nebraska, 68901, 402-461-7501

Complaints or concerns involving discrimination or needs for accommodation or access should be addressed to the appropriate Coordinator. For further information about anti-discrimination laws and regulations, or to file a complaint of discrimination with the Office for Civil Rights in the U.S. Department of Education (OCR), please contact the OCR at 601 East 12<sup>th</sup> Street, Room 353, Kansas City, MO 64106, (800) 368-1019 (voice), Fax (816) 426-3686, (800) 537-7697 (telecommunications device for the deaf), or [ocr.kansascity@ed.gov](mailto:ocr.kansascity@ed.gov).

### 2. Prohibited Harassment, Discrimination, and Retaliation of Employees, Students and Others

#### Purpose:

The Hastings Public Schools is committed to offering employment and educational opportunity to its employees and students in a climate free of discrimination. Accordingly, unlawful discrimination, harassment and retaliation of any kind by District employees, including, co-workers, non-employees (such as volunteers), third parties, and others is strictly prohibited and will not be tolerated.

Harassment is a form of discrimination and includes verbal, non-verbal, written, graphic, or physical conduct relating to a person's sex, disability, race, color, religion, veteran

status, national or ethnic origin, age, marital status, pregnancy, childbirth or related medical condition, sexual orientation or gender identity, or other protected status, that is sufficiently serious to deny, interfere with, or limit a person's ability to participate in or benefit from an educational or work program or activity, including, but not limited to:

- Conduct that is sufficiently severe or pervasive to create an intimidating, hostile, or abusive educational or work environment, or
- Requiring an individual to endure the offensive conduct as a condition of continued employment or educational programs or activities, including the receipt of aids, benefits, and services.

Educational programs and activities include all academic, educational, extracurricular, athletic, and other programs of the school, whether those programs take place in a school's facilities, on a school bus, at a class or training program sponsored by the school at another location, or elsewhere.

Discriminatory harassment because of a person's sex, disability, race, color, religion, veteran status, national or ethnic origin, age, marital status, pregnancy, childbirth or related medical condition, sexual orientation or gender identity, or other protected status, may include, but is not limited to:

- Name-calling,
- Teasing or taunting,
- Insults, slurs, or derogatory names or remarks,
- Demeaning jokes,
- Inappropriate gestures,
- Graffiti or inappropriate written or electronic material,
- Visual displays, such as cartoons, posters, or electronic images,
- Threats or intimidating or hostile conduct,
- Physical acts of aggression, assault, or violence, or
- Criminal offenses.

The following examples are additional or more specific examples of conduct that may constitute sexual harassment:

- Unwelcome sexual advances or propositions,
- Requests or pressure for sexual favors,
- Comments about an individual's body, sexual activity, or sexual attractiveness,
- Physical contact or touching of a sexual nature, including touching intimate body parts and inappropriate patting, pinching, rubbing, or brushing against another's body,
- Physical sexual acts of aggression, assault, or violence, including criminal offenses (such as rape, sexual assault or battery, and sexually motivated stalking), against a person's will or where a person is incapable of giving consent due to the victim's age, intellectual disability, or use of drugs or alcohol,
- Requiring sexual favors or contact in exchange for aids, benefits, or services, such as grades, awards, privileges, promotions, etc., or

- Gender-based harassment; acts of verbal, nonverbal, written, graphic, or physical conduct based on sex or sex-stereotyping, but not involving conduct of a sexual nature.

If the District knows or reasonably should know about possible harassment, including violence, the District will conduct a prompt, adequate, reliable, thorough, and impartial investigation to determine whether unlawful harassment occurred (see “Grievance or Complaint Procedures” in Rule 404.06), and take appropriate interim measures, if necessary. If the District determines that unlawful harassment occurred, the District will take prompt and effective action to eliminate the harassment, prevent its recurrence, and remedy its effects, if appropriate. If harassment or violence that occurs off school property creates a hostile environment at school, the District will follow this policy and grievance procedure, within the scope of its authority.

All District employees are expected to take prompt and appropriate actions to report and prevent discrimination, harassment, and retaliation by others. Employees who witness or become aware of possible discrimination, including harassment and retaliation, must immediately report the conduct to his or her supervisor or the compliance coordinator designated to handle complaints of discrimination (designated compliance coordinator).

### 3. Anti-retaliation:

The District prohibits retaliation, intimidation, threats, coercion, or discrimination against any person for opposing discrimination, including harassment, or for participating in the District's discrimination complaint process or making a complaint, testifying, assisting, or participating in any manner, in an investigation, proceeding, or hearing. Retaliation is a form of discrimination.

The District will take immediate steps to stop retaliation and prevent its recurrence against the alleged victim and any person associated with the alleged victim. These steps will include, but are not limited to, notifying students, employees, and others, that they are protected from retaliation, ensuring that they know how to report future complaints, and initiating follow-up contact with the complainant to determine if any additional acts of discrimination, harassment, or retaliation have occurred. If retaliation occurs, the District will take prompt and strong responsive action, including possible discipline, including expulsion or termination, if applicable.

Approved 10/19/2015 Reviewed 6-18-18; 7-16-18; 8-20-18; 7-13-20 Revised 8-20-18;  
7-13-20

## **ANTI-DISCRIMINATION, ANTI-HARASSMENT, AND ANTI-RETALIATION**

The Hastings Public Schools is committed to offering employment and educational opportunity to its employees and students in a climate free of discrimination. Accordingly, unlawful discrimination, harassment and retaliation of any kind by District employees, including, co-workers, non-employees (such as volunteers), third parties, and others is strictly prohibited and will not be tolerated. Should unlawful discrimination, harassment, and/or retaliation be alleged, the following shall apply.

### **Grievance or Complaint Procedures:**

Employees or students should initially report all instances of discrimination, harassment or retaliation to their immediate supervisor or teacher or to the compliance coordinator designated to handle complaints of discrimination (designated coordinator). If the employee or student is uncomfortable in presenting the problem to the supervisor or teacher, or if the supervisor or teacher is the problem, the employee or student may report the alleged discrimination, harassment or retaliation (“discrimination”) to the designated coordinator, or in the case of students, to another staff person (such as a counselor or principal).

Other individuals may report alleged discrimination to the designated coordinator. If the designated coordinator is the person alleged to have committed the discriminatory act, then the complaint should be submitted to the Superintendent for assignment. A discrimination complaint form is attached to this grievance procedure and is available in the office of each District building, on the District's website, and from the designated coordinators.

Under no circumstances will a person filing a complaint or grievance involving discrimination be retaliated against for filing the complaint or grievance.

### ***Level 1 (Investigation and Findings):***

Once the District receives a grievance, complaint or report alleging discrimination, harassment, or retaliation, or becomes aware of possible discriminatory conduct, the District will conduct a prompt, adequate, reliable, thorough, and impartial investigation to determine whether unlawful harassment occurred. If necessary, the District will take immediate, interim action or measures to protect the alleged victim and prevent further potential discrimination, harassment, or retaliation during the pending investigation. The alleged victim will be notified of his or her options to avoid contact with the alleged harasser, such as changing a class or prohibiting the alleged harasser from having any contact with the alleged victim pending the result of the District’s investigation. The District will minimize any burden on the alleged victim when taking interim measures to protect the alleged victim.

The District will promptly investigate all complaints of discrimination, even if an outside entity or law enforcement agency is investigating a complaint involving the same facts and allegations. The District will not wait for the conclusion or outcome of a criminal investigation or proceeding to begin an investigation required by this grievance procedure. If the allegation(s) involve possible criminal conduct, the District will notify the complainant of his or her right to file a criminal complaint, and District employees will not dissuade the complainant from filing a criminal complaint either during or after the District's investigation.

The District will aim to complete its investigation within **ten (10) working days** after receiving a complaint or report, unless extenuating circumstances exist. Extenuating circumstances may include the unavailability of witnesses due to illness or incapacitation, or additional time needed because of the complexity of the investigation, the need for outside experts to evaluate the evidence (such as forensic evidence), or multiple complainants or victims. If extenuating circumstances exist, the extended timeframe to complete the investigation will **not exceed ten (10) additional working days without the consent of the complainant, unless the alleged victim agrees to a longer timeline.** Periodic status updates will be given to the parties, when appropriate.

The District's investigation will include, but is not limited to:

- Providing the parties with the opportunity to present witnesses and provide evidence.
- An evaluation of all relevant information and documentation relating to the alleged discriminatory conduct.
- For allegations involving harassment, some of the factors the District will consider include: 1) the nature of the conduct and whether the conduct was unwelcome, 2) the surrounding circumstances, expectations, and relationships, 3) the degree to which the conduct affected one or more students' education, 4) the type, frequency, and duration of the conduct, 5) the identity of and relationship between the alleged harasser and the suspect or suspects of the harassment, 6) the number of individuals involved, 7) the age (and sex, if applicable) of the alleged harasser and the alleged victim(s) of the harassment, 8) the location of the incidents and the context in which they occurred, 9) the totality of the circumstances, and 10) other relevant evidence.
- A review of the evidence using a "preponderance of the evidence" standard (based on the evidence, is it more likely than not that discrimination, harassment, or retaliation occurred?)

The designated compliance coordinator (or designated investigator) will complete an investigative report, which will include:

- A summary of the facts,
- Findings regarding whether discrimination, harassment or other inappropriate conduct occurred, and
- If a finding is made that discrimination, harassment or other inappropriate

conduct occurred, the recommended remedy or remedies necessary to eliminate such discrimination, harassment or other inappropriate conduct.

If someone other than the designated compliance coordinator conducted the investigation, the compliance coordinator will review, approve, and sign the investigative report. The District will ensure that prompt, appropriate, and effective remedies are provided if a finding of discrimination, harassment, or retaliation is made. The District will maintain relevant documentation obtained during the investigation and documentation supportive of the findings and any subsequent determinations, including the investigative report, witness statements, interview summaries, and any transcripts or audio recordings, pertaining to the investigative and appeal proceedings.

The District will send concurrently to the parties written notification of the decision (findings and any remedy) regarding the complaint within **one (1) working day** after the investigation is completed. The Family Educational Rights and Privacy Act (FERPA), 20 U.S.C. § 11232g; 34 C.F.R. Part 99, permits the District to disclose relevant information to a student who was discriminated against or harassed.

*Level 2 (Appeal to the Superintendent):*

If a party is not satisfied with the findings or remedies (or both) set forth in the decision, he or she may file an appeal in writing with the Superintendent within **five (5) working days** after receiving the decision. The Superintendent will review the appeal and the investigative documentation and decision, conduct additional investigation, if necessary, and issue a written determination about the appeal **within ten (10) working days** after receiving the appeal. The party who filed the appeal will be sent the Superintendent's determination at the time it is issued, and a copy will be sent to the designated compliance coordinator. If the Superintendent is the subject of the complaint, the party will file the appeal directly with the Board.

*Level 3 (Appeal to the Board):*

If the party is not satisfied with the Superintendent's determination, he or she may file an appeal in writing with the Board of Education **within five (5) working days** after receiving the Superintendent's determination. The Board of Education will review the appeal, the Superintendent's determination, the investigative documentation and decision, and allow the party to address the Board at a Board meeting to present his or her appeal. The party will be allowed to address the Board at the Board's next regularly scheduled Board meeting (unless the Board receives the appeal within one week of the next regularly scheduled Board meeting) or at a time and date agreed to by the Board, the designated compliance officer, and the party. The Board will issue a written determination about the appeal **within thirty (30) days** after the party addresses the Board. The party who filed the appeal will be sent the Board's determination at the time it is issued, and a copy will be sent to the designated compliance coordinator. The Board's determination, and any actions taken, will be final on behalf of the District.

**Confidentiality:**

The identity of the complainant will be kept confidential to the extent permitted by state and federal law. The District will notify the complainant of the anti-retaliation provisions of applicable laws and that the District will take steps to prevent retaliation and will take prompt and strong responsive actions if retaliation occurs.

If a complainant requests confidentiality or asks that the complaint not be pursued, the District will take all reasonable steps to investigate and respond to the complaint consistent with the request for confidentiality or the request not to pursue an investigation, as long as doing so does not prevent the District from responding effectively to the harassment and preventing harassment of other students. If a complainant insists that his or her name or other identifiable information not be disclosed to the alleged perpetrator, the District will inform the complainant that its ability to respond may be limited. Even if the District cannot take disciplinary action against the alleged harasser, the District will pursue other steps to limit the effects of the alleged harassment and prevent its recurrence, if warranted

**Training:**

The District will ensure that relevant District employees are adequately trained so they understand and know how to identify acts of discrimination, harassment, and retaliation, and how to report it to appropriate District officials or employees.

In addition, the District shall ensure that employees designated to address or investigate discrimination, harassment, and retaliation, including designated compliance coordinators, receive additional specific training to promptly and effectively investigate and respond to complaints and reports of discrimination, and to know the District's grievance procedures and the applicable confidentiality requirements.

**Designated Compliance Coordinators:**

Designated compliance coordinators will be responsible for:

- Coordinating efforts to comply with anti-discrimination, anti-harassment, and anti-retaliation laws and regulations.
- Coordinating and implementing training for students and employees pertaining to anti-discrimination, anti-harassment and anti-retaliation laws and regulations, including the training areas listed above.
- Investigating complaints of discrimination (unless the coordinator designates other trained individuals to investigate).
- Monitoring substantiated complaints or reports of discrimination, as needed (and with the assistance of other District employees, if necessary), to ensure discrimination or harassment does not recur, and that retaliation conduct does not occur or recur.

- Overseeing discrimination complaints, including identifying and addressing any patterns or systemic problems, and reporting such patterns or systemic problems to the Superintendent and the Board of Education.
- Communicating regularly with the District's law enforcement unit investigating cases and providing current information to them pertaining to anti-discrimination, anti-harassment, and anti-retaliation standards and compliance requirements.
- Reviewing all evidence in harassment or violence cases to determine whether the complainants are entitled to a remedy under anti-discrimination laws and regulations that was not available in the disciplinary process.
- Ensuring that investigations address whether other students or employees may have been subjected to discrimination, including harassment and retaliation.
- Determining whether District employees with knowledge of allegations of discrimination, including harassment and retaliation, failed to carry out their duties in reporting the allegations to the designated compliance coordinator and responding to the allegations.
- Recommending changes to this policy and grievance procedure.
- Performing other duties as assigned.

### **Preventive Measures:**

The District will publish and widely distribute on an ongoing basis a notice of nondiscrimination (notice) in electronic and printed formats, including prominently displaying the notice on the District's website and posting the notice at each building in the District (see Attachment B). The District also will designate an employee to coordinate compliance with anti-discrimination laws (see Designated Compliance Coordinator section, above, for further information on compliance coordinator), and widely publish and disseminate this grievance procedure, including prominently posting it on the District's website, at each building in the District, reprinting it in District publications, such as handbooks, and sending it electronically to members of the school community. The District will provide training to employees and students at the beginning of each academic year in the areas identified in the Training section, above.

The District also may distribute specific harassment and violence materials (such as sexual violence), including a summary of the District's anti-discrimination, anti-harassment, and anti-retaliation policy and grievance procedure, and a list of victim resources, during events such as school assemblies and back to school nights, if recent incidents or allegations warrant additional education to the school community.

Approved 10/19/2015 Reviewed 6-18-18; 7-16-18; 8-20-18 Revised 8-20-18; 7-13-20

HASTINGS PUBLIC SCHOOLS

**Complaint Form  
Discrimination, Harassment or Retaliation**

The Hastings Public School District does not illegally and unjustly discriminate on the basis of sex, disability, race, color, religion, veteran status, national or ethnic origin, marital status, pregnancy, childbirth or related medical condition, sexual orientation or gender identity, or other protected status, or other protected status in its programs and activities and provides equal access to the Boy Scouts and other designated youth groups. This complaint form is to be used when a person has a complaint related to discrimination, harassment or retaliation on such bases in regard to employment or the programs and activities of the school district.

Refer to Board Policy 404.06 for particular information pertaining to the complaint and grievance process. You may attach additional materials to this form if needed.

The applicable coordinator may be contacted if you have questions about filling out this complaint form:

**Students:** Director of Special Education, 1924 West A Street, Hastings, Nebraska, 68901, 402-461-7516

**Employees and Others:** Director of Human Resources and Operations, 1924 West A Street, Hastings, Nebraska, 68901, 402-461-7501

Name: \_\_\_\_\_ Date: \_\_\_\_\_

(1) Description of the complaint: \_\_\_\_\_

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(2) Names of any witnesses to the matter being complained about: \_\_\_\_\_

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(3) Identify and attach any document supporting the complaint: \_\_\_\_\_

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(4) Confidentiality: I (check one) \_\_\_ do \_\_\_ do not give consent to my identity being shared with the person(s) against whom I am complaining. If I do not give consent, I understand that the investigation may be hindered, but that the District will nonetheless investigate and take prompt and effective action to remediate the concerns I have raised, if appropriate.

(5) Relief requested (what I want done in response to this complaint): \_\_\_\_\_

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The undersigned states: The facts in this complaint are true to the best of my knowledge, information and belief. I give permission for an investigation to be made into this complaint. I understand that the District will take steps to prevent me being retaliated against for filing this complaint, that I am to notify the District if any such retaliation occurs, and that the District will take prompt and strong responsive action if retaliation occurs.

Signature: \_\_\_\_\_

**For HPS Use Only**

\*\*\*\*\*

Received by: \_\_\_\_\_ Date: \_\_\_\_\_

### **Notice of Nondiscrimination**

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## **ANTI-DISCRIMINATION, ANTI-HARASSMENT, AND ANTI-RETALIATION**

### 1. Elimination of Discrimination

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The Hastings Public Schools does not illegally and unjustly discriminate on the basis of sex, disability, race (including skin color, hair texture, and protective hairstyles), color, religion, veteran status, national or ethnic origin, marital status, pregnancy, childbirth or related medical condition, sexual orientation or gender identity, or other protected status in its programs and activities and provides equal access to the Boy Scouts and other designated youth groups. Reasonable accommodations will be provided to employees with disabilities and to those who are pregnant, have given birth, or have a related medical condition, as required by law. The following persons have been designated as “Coordinators” to handle inquiries regarding the non-discrimination policies:

Students: Director of Special Education, 1924 West A Street, Hastings, Nebraska, 68901, 402-461-7516

Employees and Others: Director of Human Resources and Operations, 1924 West A Street, Hastings, Nebraska, 68901, 402-461-7501

Complaints or concerns involving discrimination or needs for accommodation or access should be addressed to the appropriate Coordinator. For further information about anti-discrimination laws and regulations, or to file a complaint of discrimination with the Office for Civil Rights in the U.S. Department of Education (OCR), please contact the OCR at 601 East 12<sup>th</sup> Street, Room 353, Kansas City, MO 64106, (800) 368-1019 (voice), Fax (816) 426-3686, (800) 537-7697 (telecommunications device for the deaf), or [ocr.kansascity@ed.gov](mailto:ocr.kansascity@ed.gov).

### 2. Prohibited Harassment, Discrimination, and Retaliation of Employees, Students and Others

#### Purpose:

The Hastings Public Schools is committed to offering employment and educational opportunity to its employees and students in a climate free of discrimination. Accordingly, unlawful discrimination, harassment and retaliation of any kind by District employees, including, co-workers, non-employees (such as volunteers), third parties, and others is strictly prohibited and will not be tolerated.

Harassment is a form of discrimination and includes verbal, non-verbal, written, graphic, or physical conduct relating to a person's sex, disability, race (including skin color, hair texture, and protective hairstyles), color, religion, veteran status, national or ethnic origin, age, marital status, pregnancy, childbirth or related medical condition, sexual

orientation or gender identity, or other protected status, that is sufficiently serious to deny, interfere with, or limit a person's ability to participate in or benefit from an educational or work program or activity, including, but not limited to:

- Conduct that is sufficiently severe or pervasive to create an intimidating, hostile, or abusive educational or work environment, or
- Requiring an individual to endure the offensive conduct as a condition of continued employment or educational programs or activities, including the receipt of aids, benefits, and services.

Educational programs and activities include all academic, educational, extracurricular, athletic, and other programs of the school, whether those programs take place in a school's facilities, on a school bus, at a class or training program sponsored by the school at another location, or elsewhere.

Discriminatory harassment because of a person's sex, disability, race (including skin color, hair texture, and protective hairstyles), color, religion, veteran status, national or ethnic origin, age, marital status, pregnancy, childbirth or related medical condition, sexual orientation or gender identity, or other protected status, may include, but is not limited to:

- Name-calling,
- Teasing or taunting,
- Insults, slurs, or derogatory names or remarks,
- Demeaning jokes,
- Inappropriate gestures,
- Graffiti or inappropriate written or electronic material,
- Visual displays, such as cartoons, posters, or electronic images,
- Threats or intimidating or hostile conduct,
- Physical acts of aggression, assault, or violence, or
- Criminal offenses.

The following examples are additional or more specific examples of conduct that may constitute sexual harassment:

- Unwelcome sexual advances or propositions,
- Requests or pressure for sexual favors,
- Comments about an individual's body, sexual activity, or sexual attractiveness,
- Physical contact or touching of a sexual nature, including touching intimate body parts and inappropriate patting, pinching, rubbing, or brushing against another's body,
- Physical sexual acts of aggression, assault, or violence, including criminal offenses (such as rape, sexual assault or battery, and sexually motivated stalking), against a person's will or where a person is incapable of giving consent due to the victim's age, intellectual disability, or use of drugs or alcohol,
- Requiring sexual favors or contact in exchange for aids, benefits, or services, such as grades, awards, privileges, promotions, etc., or

- Gender-based harassment; acts of verbal, nonverbal, written, graphic, or physical conduct based on sex or sex-stereotyping, but not involving conduct of a sexual nature.

If the District knows or reasonably should know about possible harassment, including violence, the District will conduct a prompt, adequate, reliable, thorough, and impartial investigation to determine whether unlawful harassment occurred (see “Grievance or Complaint Procedures” in Rule 404.06), and take appropriate interim measures, if necessary. If the District determines that unlawful harassment occurred, the District will take prompt and effective action to eliminate the harassment, prevent its recurrence, and remedy its effects, if appropriate. If harassment or violence that occurs off school property creates a hostile environment at school, the District will follow this policy and grievance procedure, within the scope of its authority.

All District employees are expected to take prompt and appropriate actions to report and prevent discrimination, harassment, and retaliation by others. Employees who witness or become aware of possible discrimination, including harassment and retaliation, must immediately report the conduct to his or her supervisor or the compliance coordinator designated to handle complaints of discrimination (designated compliance coordinator).

### 3. Anti-retaliation:

The District prohibits retaliation, intimidation, threats, coercion, or discrimination against any person for opposing discrimination, including harassment, or for participating in the District's discrimination complaint process or making a complaint, testifying, assisting, or participating in any manner, in an investigation, proceeding, or hearing. Retaliation is a form of discrimination.

The District will take immediate steps to stop retaliation and prevent its recurrence against the alleged victim and any person associated with the alleged victim. These steps will include, but are not limited to, notifying students, employees, and others, that they are protected from retaliation, ensuring that they know how to report future complaints, and initiating follow-up contact with the complainant to determine if any additional acts of discrimination, harassment, or retaliation have occurred. If retaliation occurs, the District will take prompt and strong responsive action, including possible discipline, including expulsion or termination, if applicable.

Approved 10/19/2015 Reviewed 6-18-18; 7-16-18; 8-20-18; 7-13-20 Revised 8-20-18;  
7-13-20

HASTINGS PUBLIC SCHOOLS

## **ANTI-DISCRIMINATION, ANTI-HARASSMENT, AND ANTI-RETALIATION**

The Hastings Public Schools is committed to offering employment and educational opportunity to its employees and students in a climate free of discrimination. Accordingly, unlawful discrimination, harassment and retaliation of any kind by District employees, including, co-workers, non-employees (such as volunteers), third parties, and others is strictly prohibited and will not be tolerated. Should unlawful discrimination, harassment, and/or retaliation be alleged, the following shall apply.

### **Grievance or Complaint Procedures:**

Employees or students should initially report all instances of discrimination, harassment or retaliation to their immediate supervisor or teacher or to the compliance coordinator designated to handle complaints of discrimination (designated coordinator). If the employee or student is uncomfortable in presenting the problem to the supervisor or teacher, or if the supervisor or teacher is the problem, the employee or student may report the alleged discrimination, harassment or retaliation ("discrimination") to the designated coordinator, or in the case of students, to another staff person (such as a counselor or principal).

Other individuals may report alleged discrimination to the designated coordinator. If the designated coordinator is the person alleged to have committed the discriminatory act, then the complaint should be submitted to the Superintendent for assignment. A discrimination complaint form is attached to this grievance procedure and is available in the office of each District building, on the District's website, and from the designated coordinators.

Under no circumstances will a person filing a complaint or grievance involving discrimination be retaliated against for filing the complaint or grievance.

#### *Level 1 (Investigation and Findings):*

Once the District receives a grievance, complaint or report alleging discrimination, harassment, or retaliation, or becomes aware of possible discriminatory conduct, the District will conduct a prompt, adequate, reliable, thorough, and impartial investigation to determine whether unlawful harassment occurred. If necessary, the District will take immediate, interim action or measures to protect the alleged victim and prevent further potential discrimination, harassment, or retaliation during the pending investigation. The alleged victim will be notified of his or her options to avoid contact with the alleged harasser, such as changing a class or prohibiting the alleged harasser from having any contact with the alleged victim pending the result of the District's investigation. The District will minimize any burden on the alleged victim when taking interim measures to protect the alleged victim.

The District will promptly investigate all complaints of discrimination, even if an outside entity or law enforcement agency is investigating a complaint involving the same facts and allegations. The District will not wait for the conclusion or outcome of a criminal investigation or proceeding to begin an investigation required by this grievance

procedure. If the allegation(s) involve possible criminal conduct, the District will notify the complainant of his or her right to file a criminal complaint, and District employees will not dissuade the complainant from filing a criminal complaint either during or after the District's investigation.

The District will aim to complete its investigation within **ten (10) working days** after receiving a complaint or report, unless extenuating circumstances exist. Extenuating circumstances may include the unavailability of witnesses due to illness or incapacitation, or additional time needed because of the complexity of the investigation, the need for outside experts to evaluate the evidence (such as forensic evidence), or multiple complainants or victims. If extenuating circumstances exist, the extended timeframe to complete the investigation will **not exceed ten (10) additional working days without the consent of the complainant, unless the alleged victim agrees to a longer timeline.** Periodic status updates will be given to the parties, when appropriate.

The District's investigation will include, but is not limited to:

- Providing the parties with the opportunity to present witnesses and provide evidence.
- An evaluation of all relevant information and documentation relating to the alleged discriminatory conduct.
- For allegations involving harassment, some of the factors the District will consider include: 1) the nature of the conduct and whether the conduct was unwelcome, 2) the surrounding circumstances, expectations, and relationships, 3) the degree to which the conduct affected one or more students' education, 4) the type, frequency, and duration of the conduct, 5) the identity of and relationship between the alleged harasser and the suspect or suspects of the harassment, 6) the number of individuals involved, 7) the age (and sex, if applicable) of the alleged harasser and the alleged victim(s) of the harassment, 8) the location of the incidents and the context in which they occurred, 9) the totality of the circumstances, and 10) other relevant evidence.
- A review of the evidence using a "preponderance of the evidence" standard (based on the evidence, is it more likely than not that discrimination, harassment, or retaliation occurred?)

The designated compliance coordinator (or designated investigator) will complete an investigative report, which will include:

- A summary of the facts,
- Findings regarding whether discrimination, harassment or other inappropriate conduct occurred, and
- If a finding is made that discrimination, harassment or other inappropriate conduct occurred, the recommended remedy or remedies necessary to eliminate such discrimination, harassment or other inappropriate conduct.

If someone other than the designated compliance coordinator conducted the investigation, the compliance coordinator will review, approve, and sign the investigative report. The District will ensure that prompt, appropriate, and effective remedies are

provided if a finding of discrimination, harassment, or retaliation is made. The District will maintain relevant documentation obtained during the investigation and documentation supportive of the findings and any subsequent determinations, including the investigative report, witness statements, interview summaries, and any transcripts or audio recordings, pertaining to the investigative and appeal proceedings.

The District will send concurrently to the parties written notification of the decision (findings and any remedy) regarding the complaint within **one (1) working day** after the investigation is completed. The Family Educational Rights and Privacy Act (FERPA), 20 U.S.C. § 11232g; 34 C.F.R. Part 99, permits the District to disclose relevant information to a student who was discriminated against or harassed.

*Level 2 (Appeal to the Superintendent):*

If a party is not satisfied with the findings or remedies (or both) set forth in the decision, he or she may file an appeal in writing with the Superintendent within **five (5) working days** after receiving the decision. The Superintendent will review the appeal and the investigative documentation and decision, conduct additional investigation, if necessary, and issue a written determination about the appeal **within ten (10) working days** after receiving the appeal. The party who filed the appeal will be sent the Superintendent's determination at the time it is issued, and a copy will be sent to the designated compliance coordinator. If the Superintendent is the subject of the complaint, the party will file the appeal directly with the Board.

*Level 3 (Appeal to the Board):*

If the party is not satisfied with the Superintendent's determination, he or she may file an appeal in writing with the Board of Education **within five (5) working days** after receiving the Superintendent's determination. The Board of Education will review the appeal, the Superintendent's determination, the investigative documentation and decision, and allow the party to address the Board at a Board meeting to present his or her appeal. The party will be allowed to address the Board at the Board's next regularly scheduled Board meeting (unless the Board receives the appeal within one week of the next regularly scheduled Board meeting) or at a time and date agreed to by the Board, the designated compliance officer, and the party. The Board will issue a written determination about the appeal **within thirty (30) days** after the party addresses the Board. The party who filed the appeal will be sent the Board's determination at the time it is issued, and a copy will be sent to the designated compliance coordinator. The Board's determination, and any actions taken, will be final on behalf of the District.

**Confidentiality:**

The identity of the complainant will be kept confidential to the extent permitted by state and federal law. The District will notify the complainant of the anti-retaliation provisions of applicable laws and that the District will take steps to prevent retaliation and will take prompt and strong responsive actions if retaliation occurs.

If a complainant requests confidentiality or asks that the complaint not be pursued, the District will take all reasonable steps to investigate and respond to the complaint consistent with the request for confidentiality or the request not to pursue an investigation, as long as doing so does not prevent the District from responding effectively to the harassment and preventing harassment of other students. If a complainant insists that his or her name or other identifiable information not be disclosed to the alleged perpetrator, the District will inform the complainant that its ability to respond may be limited. Even if the District cannot take disciplinary action against the alleged harasser, the District will pursue other steps to limit the effects of the alleged harassment and prevent its recurrence, if warranted

### **Training:**

The District will ensure that relevant District employees are adequately trained so they understand and know how to identify acts of discrimination, harassment, and retaliation, and how to report it to appropriate District officials or employees.

In addition, the District shall ensure that employees designated to address or investigate discrimination, harassment, and retaliation, including designated compliance coordinators, receive additional specific training to promptly and effectively investigate and respond to complaints and reports of discrimination, and to know the District's grievance procedures and the applicable confidentiality requirements.

### **Designated Compliance Coordinators:**

Designated compliance coordinators will be responsible for:

- Coordinating efforts to comply with anti-discrimination, anti-harassment, and anti-retaliation laws and regulations.
- Coordinating and implementing training for students and employees pertaining to anti-discrimination, anti-harassment and anti-retaliation laws and regulations, including the training areas listed above.
- Investigating complaints of discrimination (unless the coordinator designates other trained individuals to investigate).
- Monitoring substantiated complaints or reports of discrimination, as needed (and with the assistance of other District employees, if necessary), to ensure discrimination or harassment does not recur, and that retaliation conduct does not occur or recur.
- Overseeing discrimination complaints, including identifying and addressing any patterns or systemic problems, and reporting such patterns or systemic problems to the Superintendent and the Board of Education.
- Communicating regularly with the District's law enforcement unit investigating cases and providing current information to them pertaining to anti-discrimination, anti-harassment, and anti-retaliation standards and compliance requirements.
- Reviewing all evidence in harassment or violence cases to determine whether the complainants are entitled to a remedy under anti-discrimination laws and regulations that was not available in the disciplinary process.

- Ensuring that investigations address whether other students or employees may have been subjected to discrimination, including harassment and retaliation.
- Determining whether District employees with knowledge of allegations of discrimination, including harassment and retaliation, failed to carry out their duties in reporting the allegations to the designated compliance coordinator and responding to the allegations.
- Recommending changes to this policy and grievance procedure.
- Performing other duties as assigned.

**Preventive Measures:**

The District will publish and widely distribute on an ongoing basis a notice of nondiscrimination (notice) in electronic and printed formats, including prominently displaying the notice on the District's website and posting the notice at each building in the District (see Attachment B). The District also will designate an employee to coordinate compliance with anti-discrimination laws (see Designated Compliance Coordinator section, above, for further information on compliance coordinator), and widely publish and disseminate this grievance procedure, including prominently posting it on the District's website, at each building in the District, reprinting it in District publications, such as handbooks, and sending it electronically to members of the school community. The District will provide training to employees and students at the beginning of each academic year in the areas identified in the Training section, above.

The District also may distribute specific harassment and violence materials (such as sexual violence), including a summary of the District's anti-discrimination, anti-harassment, and anti-retaliation policy and grievance procedure, and a list of victim resources, during events such as school assemblies and back to school nights, if recent incidents or allegations warrant additional education to the school community.

Approved 10/19/2015 Reviewed 6-18-18; 7-16-18; 8-20-18 Revised 8-20-18; 7-13-20

HASTINGS PUBLIC SCHOOLS

### **Complaint Form Discrimination, Harassment or Retaliation**

The Hastings Public School District does not illegally and unjustly discriminate on the basis of sex, disability, race (including skin color, hair texture, and protective hairstyles), color, religion, veteran status, national or ethnic origin, marital status, pregnancy, childbirth or related medical condition, sexual orientation or gender identity, or other protected status, or other protected status in its programs and activities and provides equal access to the Boy Scouts and other designated youth groups. This complaint form is to be used when a person has a complaint related to discrimination, harassment or retaliation on such bases in regard to employment or the programs and activities of the school district.

Refer to Board Policy 404.06 for particular information pertaining to the complaint and grievance process. You may attach additional materials to this form if needed.

The applicable coordinator may be contacted if you have questions about filling out this complaint form:

**Students:** Director of Special Education, 1924 West A Street, Hastings, Nebraska, 68901, 402-461-7516

**Employees and Others:** Director of Human Resources and Operations, 1924 West A Street, Hastings, Nebraska, 68901, 402-461-7501

Name: \_\_\_\_\_ Date: \_\_\_\_\_

(1) Description of the complaint: \_\_\_\_\_

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(2) Names of any witnesses to the matter being complained about: \_\_\_\_\_

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(3) Identify and attach any document supporting the complaint: \_\_\_\_\_

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(4) Confidentiality: I (check one) \_\_\_ do \_\_\_ do not give consent to my identity being shared with the person(s) against whom I am complaining. If I do not give consent, I understand that the investigation may be hindered, but that the District will nonetheless investigate and take prompt and effective action to remediate the concerns I have raised, if appropriate.

(5) Relief requested (what I want done in response to this complaint): \_\_\_\_\_

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The undersigned states: The facts in this complaint are true to the best of my knowledge, information and belief. I give permission for an investigation to be made into this complaint. I understand that the District will take steps to prevent me being retaliated against for filing this complaint, that I am to notify the District if any such retaliation occurs, and that the District will take prompt and strong responsive action if retaliation occurs.

Signature: \_\_\_\_\_

**For HPS Use Only**

\*\*\*\*\*

Received by: \_\_\_\_\_ Date: \_\_\_\_\_

## Notice of Nondiscrimination

The Hastings Public School District does not illegally and unjustly discriminate on the basis of sex, disability, race (including skin color, hair texture, and protective hairstyles), color, religion, veteran status, national or ethnic origin, marital status, pregnancy, childbirth, sexual orientation or gender identity, or related medical condition, or other protected status in its programs and activities and provides equal access to the Boy Scouts and other designated youth groups. The following persons have been designated to handle inquiries regarding the non-discrimination policies:

Students: Director of Special Education, 1924 West A Street, Hastings, Nebraska, 68901, 402-461-7516

Employees and Others: Director of Human Resources and Operations, 1924 West A Street, Hastings, Nebraska, 68901, 402-461-7501

Complaints or concerns involving discrimination or needs for accommodation or access should be addressed to the appropriate Coordinator. For further information about anti-discrimination laws and regulations, or to file a complaint of discrimination with the Office for Civil Rights in the U.S. Department of Education (OCR), please contact the OCR at 601 East 12<sup>th</sup> Street, Room 353, Kansas City, MO 64106, (800) 368-1019 (voice), Fax (816) 426-3686, (800) 537-7697 (telecommunications device for the deaf), or [ocr.kansascity@ed.gov](mailto:ocr.kansascity@ed.gov).

## **EQUAL EMPLOYMENT OPPORTUNITY**

The Hastings Public Schools shall provide equal opportunity to employees and applicants for employment in accordance with applicable equal employment opportunity and directives and regulations of federal, state and local governing bodies. Opportunity to all employees and applicants for employment includes hiring, placement, promotion, transfer or demotion, recruitment, advertising or solicitation for employment, treatment during employment, rates of pay or other forms of compensation, and layoff or termination. Employees will support and comply with the District's established equal employment opportunity policies. Employees shall be given notice of this policy annually.

The Board shall appoint the Superintendent as equal employment opportunity coordinator. The equal employment opportunity coordinator shall have the responsibility for drafting the equal employment opportunity plan. The equal employment opportunity plan shall be reviewed by the Board at least every two (2) years.

Individuals who file an application with the School District will be given consideration for employment if they meet or exceed the qualifications set by the Board, administration, and Nebraska Department of Education for the position for which they apply. In employing individuals, the Board shall consider the qualifications, credentials, and records of the applicants without regard to sex, disability, race, color, religion, veteran status, national or ethnic origin, marital status, pregnancy, childbirth or related medical condition, sexual orientation or gender identity, or other protected status. In keeping with the law, the Board shall consider the veteran status of applicants.

Advertisements and notices for vacancies within the District shall contain the following statement: "The Hastings Public School District is an equal employment opportunity employer." The statement shall also appear on application forms.

Inquiries by employees or applicants for employment regarding compliance with equal employment opportunity laws and policies including, but not limited to, complaints of discrimination shall be directed to the Equal Employment Opportunity Coordinator by writing to the EEO Coordinator, Hastings Public School District, 1924 West A Street, Hastings, Nebraska, or by telephoning 402-461-7500.

Inquiries by employees or applicants for employment regarding compliance with equal employment opportunity laws and policies, including but not limited to complaints of discrimination, may also be directed in writing to the Director of the Kansas Office of Civil Rights, U.S. Department of Education, 8930 Ward Parkway, Suite 2037, Kansas City, MO 64114-3302, (816) 268-0550 or the Nebraska Equal Opportunity Commission, State Office Building, 301 Centennial

Mall South, 5th floor, P.O. Box 94934, Lincoln, NE 68509-4934, (402) 471-2024 or (800) 642-6112.

This inquiry or complaint to the federal office may be done instead of, or in addition to, an inquiry or complaint at the local level.

Further information and copies of the procedures for filing a complaint are available in the School District's central administrative office and the administrative office in each attendance center.

Legal Reference: 29 U.S.C. §§ 621-634 (1994).  
42 U.S.C. §§ 2000e et seq. (1994).  
42 U.S.C. §§ 12101 et seq. (1994).

Cross Reference: 103 Equal Educational Opportunity  
404.06 Harassment  
406.02 Certificated Employee Qualifications,  
Recruitment and Selection  
412.02 Classified Staff Qualifications, Recruitment and  
Selection

HASTINGS PUBLIC SCHOOLS

## **EQUAL EMPLOYMENT OPPORTUNITY**

The Hastings Public Schools shall provide equal opportunity to employees and applicants for employment in accordance with applicable equal employment opportunity and directives and regulations of federal, state and local governing bodies. Opportunity to all employees and applicants for employment includes hiring, placement, promotion, transfer or demotion, recruitment, advertising or solicitation for employment, treatment during employment, rates of pay or other forms of compensation, and layoff or termination. Employees will support and comply with the District's established equal employment opportunity policies. Employees shall be given notice of this policy annually.

The Board shall appoint the Superintendent as equal employment opportunity coordinator. The equal employment opportunity coordinator shall have the responsibility for drafting the equal employment opportunity plan. The equal employment opportunity plan shall be reviewed by the Board at least every two (2) years.

Individuals who file an application with the School District will be given consideration for employment if they meet or exceed the qualifications set by the Board, administration, and Nebraska Department of Education for the position for which they apply. In employing individuals, the Board shall consider the qualifications, credentials, and records of the applicants without regard to sex, disability, race (including skin color, hair texture, and protective hairstyles), color, religion, veteran status, national or ethnic origin, marital status, pregnancy, childbirth or related medical condition, sexual orientation or gender identity, or other protected status. In keeping with the law, the Board shall consider the veteran status of applicants.

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Nebraska Equal Opportunity Commission, State Office Building, 301 Centennial Mall South, 5th floor, P.O. Box 94934, Lincoln, NE 68509-4934, (402) 471-2024 or (800) 642-6112.

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42 U.S.C. §§ 2000e et seq. (1994).  
42 U.S.C. §§ 12101 et seq. (1994).

Cross Reference: 103 Equal Educational Opportunity  
404.06 Harassment  
406.02 Certificated Employee Qualifications,  
Recruitment and Selection  
412.02 Classified Staff Qualifications, Recruitment and  
Selection

Approved 11-18-02 Reviewed 12-17-12; 9-17-18 Revised 12-17-12; 9-17-18; 7-13-2020

HASTINGS PUBLIC SCHOOLS

## **FAMILY AND MEDICAL LEAVE-ALL EMPLOYEES**

Family and medical leaves shall be allowed under the terms and conditions of the Family and Medical Leave Act of 1993 (FMLA) as amended.

The "leave year" for purposes of the FMLA shall be a "rolling" twelve-month period, measured backward from the date of any FMLA leave usage.

Substitution of accrued paid leaves for otherwise unpaid FMLA leaves will be required. The employee will have paid leave run concurrently with unpaid FMLA leave entitlement, provided the employee meets applicable requirements of the leave policy.

Employees shall be required to submit medical certifications to support a request for FMLA leave because of a serious health condition, or a sick leave, when such leave is for a duration in excess of five (5) successive days, and in such other cases as deemed appropriate by the Superintendent or the Board based on the nature of the illness or other circumstances surrounding the leave. Second and third medical opinions may, in the Superintendent or the Board's discretion, be required. Employees shall be required to report periodically, at such times as requested by the Superintendent or the Board, on their intent to return to work from FMLA leaves and other leaves. Employees shall be required to submit a fitness-for-duty certification from their health care provider as a condition of returning to work from a FMLA leave taken because of the employee's serious health condition, or from a sick leave taken by reason of the employee's illness, when such leave was of a duration in excess of five (5) successive days, and upon request of the Superintendent or the Board when such is deemed appropriate by the Superintendent or the Board based upon the nature of the illness or other circumstances surrounding the leave.

An "equivalent position" for FMLA restoration purposes shall, in the case of certificated employees, be any administrative, teaching, or instruction related position for which the employee is qualified by reason of endorsement, college preparation, experience, or other indicia; in the case of coaching or other similar extracurricular duty assignments, be any extracurricular duty assignment, and in the case of other employees or positions, be in a position with or at equivalent pay, benefits, and working conditions, involving similar or related duties, as determined by the Superintendent or the Board.

The documents provided in response to the Family Medical Leave Act (FMLA) regulations are:

1. FMLA Leave Application
2. Notice of Eligibility and Rights and Responsibilities - Rolling Year
3. Designation Notice

4. Certification of Health Care Provider for Employee's Serious Health Condition
5. Certification of Health Care Provider for Family Member's Serious Health Condition
6. Certification of Qualifying Exigency for Military Family Leave
7. Family Military Leave Certification for Serious Injury of Servicemember

Legal Reference: 29 USC §§ 2611 to 2618 and  
29 CFR Part 82

Approved

Reviewed

Revised

HASTINGS PUBLIC SCHOOLS

**Application for Leave  
Family and Medical Leave Act**

Employee Name: \_\_\_\_\_ Title/Position: \_\_\_\_\_

Building/Dept: \_\_\_\_\_ Supervisor: \_\_\_\_\_

**FMLA Leave Requested** From Date: \_\_\_\_\_ Return Date: \_\_\_\_\_

Hire Date: \_\_\_\_\_

If leave is requested on an intermittent or reduced leave schedule, describe the requested leave schedule: \_\_\_\_\_

**Reason for Leave Request** (check and complete as appropriate):

1. For birth of a son or daughter, and to care for the newborn child.  
Expected date of birth: \_\_\_\_\_ Actual date of birth: \_\_\_\_\_
  
2. For placement with the employee of a son or daughter for adoption or foster care.  
Date of placement: \_\_\_\_\_
  
3. To care for the employee's spouse, son or daughter, or parent with a serious health condition.  
Name of family member: \_\_\_\_\_  
Describe reason employee needs to provide the care and the nature of the care:  
\_\_\_\_\_
  
4. Because of a serious health condition that makes the employee unable to perform the functions of the employee's job.  
Briefly describe condition and job functions that employee is unable to perform:  
\_\_\_\_\_
  
5. Because of a qualifying exigency arising out of the fact that the employee's spouse, son or daughter, or parent is a covered military member on active duty (or has been notified of an impending call or order to active duty) in support of a contingency operation.  
Name and relationship of family member: \_\_\_\_\_  
Describe the qualifying exigency: \_\_\_\_\_
  
6. To care for a covered service member with a serious injury or illness if the employee is the spouse, son, daughter, parent, or next of kin of the service member.  
Name and relationship of family member: \_\_\_\_\_  
Describe reason employee needs to provide the care and the nature of the care:  
\_\_\_\_\_

certify that the above information given by me is correct and that I have read the foregoing and understand my rights under the FMLA.

\_\_\_\_\_  
Employee's Signature

\_\_\_\_\_  
Date

## Notice of Eligibility and Rights & Responsibilities Family and Medical Leave Act

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In general, to be eligible an employee must have worked for an employer for at least 12 months, meet the hours of service requirement in the 12 months preceding the leave, and work at a site with at least 50 employees within 75 miles. This form is to be provided within five business days of the employee notifying the employer of the need for FMLA leave. Part B provides employees with information regarding their rights and responsibilities for taking FMLA leave.

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### Part A • NOTICE OF ELIGIBILITY

TO: \_\_\_\_\_  
Employee

FROM: HPS Superintendent

DATE: \_\_\_\_\_

On \_\_\_\_\_, you informed us that you needed leave beginning on \_\_\_\_\_ through \_\_\_\_\_ for:

The birth of a child, or placement of a child with you for adoption or foster care;

Your own serious health condition;

Because you are needed to care for your \_\_\_ spouse; \_\_\_ son or daughter; parent due to his/her serious health condition.

Because of a qualifying exigency arising out of the fact that your \_\_\_ spouse; \_\_\_ son or daughter; \_\_\_ parent is on covered active duty or call to covered active duty with the Armed Forces.

Because you are the \_\_\_ spouse; \_\_\_ son or daughter; \_\_\_ parent next of kin of a covered service member with a serious injury or illness.

This Notice is to inform you that you:

Are eligible for FMLA leave (See Part B below for Rights and Responsibilities).

Are **NOT** eligible for FMLA leave, because (only one reason need be checked, although you may not be eligible for other reasons):

You have not met the FMLA's 12-month length of service requirement. As of the first date of requested leave, you will have worked approximately \_\_\_ months towards this requirement.

You have not met the FMLA's hours of service requirement.

If you have any questions, contact the Superintendent's Office or view the FMLA poster located in your building's information office.

### Part B • RIGHTS AND RESPONSIBILITIES FOR TAKING FMLA LEAVE

As explained in Part A, you meet the eligibility requirements for taking FMLA leave and still have FMLA leave available in the applicable 12-month period. **However, in order for us to determine whether your absence qualifies as FMLA leave, you must return the following information to us by \_\_\_\_\_.** (If a certification is requested, employers must allow at least 15 calendar days from receipt of this notice; additional time may be required in some circumstances). If sufficient information is not provided in a timely manner, your leave may be denied.

Sufficient certification to support your request for FMLA leave. **A** certification form that sets forth the information necessary to support your request \_\_\_ is / **is not** enclosed.

Sufficient documentation to establish the required relationship between you and your family member.

Other information needed (such as documentation for military family leave):

\_\_\_\_\_

No additional information requested.

If your leave **does qualify** as FMLA leave you will have the following responsibilities while on FMLA leave (only checked blanks apply):

Contact \_\_\_\_\_ at \_\_\_\_\_ to make arrangements to continue to make your share of the premium payments on your health insurance to maintain health benefits while you are on leave. You have a minimum 30-day (or, indicate longer period, if applicable) grace period in which to make premium payments. If payment is not made timely, your group health insurance may be cancelled, provided we notify you in writing at least 15 days before the date that your health coverage will lapse, or, at our option, we may pay your share of the premiums during FMLA leave, and recover these payments from you upon your return to work.

\_\_\_ You will be required to use your available \_\_\_ sick, \_\_\_ vacation, and/or other **leave** during your FMLA absence. This means that you will receive your paid leave and the leave will also be considered protected FMLA leave and counted against your FMLA leave entitlement.

Due to your status within the district, you are considered a "key employee" as defined in the FMLA. As a "key employee," restoration to employment may be denied following FMLA leave on the grounds that such restoration will cause substantial and grievous economic injury to us. We \_\_\_ **have/** \_\_\_ **have not** determined that restoring you to employment at the conclusion of FMLA leave will cause substantial and grievous economic harm to us.

While on leave you will be required to furnish us with periodic reports of your status and intent to return to work every \_\_\_\_\_

**If the circumstances of your leave change, and you are able to return to work earlier than the date indicated on this form, you will be required to notify us at least two workdays prior to the date you intend to report for work.**

**If your leave does qualify** as FMLA leave you will have the following **rights** while on FMLA leave:

- You have a right under the FMLA for up to 12 weeks of unpaid leave in a 12-month period calculated as a "rolling" 12-month period measured backward from the date of any FMLA leave usage.
- You have a right under the FMLA for up to 26 weeks of unpaid leave in a single 12-month period to care for a covered service member with a serious injury or illness. This single 12-month period commenced on \_\_\_\_\_
- Your health benefits must be maintained during any period of unpaid leave under the same conditions as if you continued to work.
- You must be reinstated to the same or an equivalent job with the same pay, benefits, and terms and conditions of employment on your return from FMLA-protected leave. (If your leave extends beyond the end of your FMLA entitlement, you do not have return rights under FMLA.)

- If you do not return to work following FMLA leave for a reason other than: (1) the continuation, recurrence, or onset of a serious health condition which would entitle you to FMLA leave; (2) the continuation, recurrence, or onset of a covered service member's serious injury or illness which would entitle you to FMLA leave; or (3) other circumstances beyond your control, you may be required to reimburse us for our share of health insurance premiums paid on your behalf during your FMLA leave.

For a copy of conditions applicable to sick/vacation/other leave usage please refer to the appropriate handbook/agreement available at the District Office.

Applicable conditions for use of paid leave: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Once we obtain the information from you as specified above, we will inform you, within five business days, whether your leave will be designated as FMLA leave and count towards your FMLA leave entitlement. If you have any questions, please do not hesitate to contact: \_\_\_\_\_

\_\_\_\_\_ at \_\_\_\_\_

## Designation Notice Family and Medical Leave Act

Leave covered under the FMLA must be designated as FMLA-protected and the employer must inform the employee of the amount of leave that will be counted against the employee's FMLA leave entitlement. In order to determine whether leave is covered under the FMLA, the employer may request that the leave be supported by a certification. If the certification is incomplete or insufficient, the employer must state in writing what additional information is necessary to make the certification complete and sufficient.

To: \_\_\_\_\_ Date: \_\_\_\_\_

We have reviewed your request for leave under the FMLA and any supporting documentation that you have provided. We received your most recent information on \_\_\_\_\_ and decided:

**\*\*APPROVED\*\***

**Your FMLA leave request is approved. All leave taken for this reason will be designated as FMLA leave.**

The FMLA requires that you notify us as soon as practicable if dates of scheduled leave change or are extended, or were initially unknown. Based on the information you have provided to date, we are providing the following information about the amount of time that will be counted against your leave entitlement:

Provided there is no deviation from your anticipated leave schedule, the following number of hours, days, or weeks will be counted against your leave-entitlement:

Because the leave you will need will be unscheduled, it is not possible to provide the hours, days, or weeks that will be counted against your FMLA entitlement at this time. You have the right to request this information once in a 30-day period (if leave was taken in the 30-day period).

Please be advised (check if applicable):

You have requested to use paid leave during your FMLA leave. Any paid leave taken for this reason will count against your FMLA leave entitlement.

We are requiring you to substitute or use paid leave during your FMLA leave.

You will be required to present a fitness-for-duty certificate to be restored to employment. If such certification is not timely received, your return to work may be delayed until certification is provided. A list of the essential functions of your position is **not** attached. If attached, the fitness-for-duty certification must address your ability to perform these functions.

**\*\*\*ADDITIONAL INFORMATION NEEDED\*\*\***

**Additional information is needed to determine if your FMLA leave request can be approved:**

The certification you have provided is not complete and sufficient to determine whether the FMLA applies to your leave request. You must provide the following information to make certification complete and sufficient no later than \_\_\_\_\_ (provide at least seven calendar days), unless it is not practicable under the particular circumstances despite your diligent good faith efforts, or your leave may be denied:

We are exercising our right to have you obtain a second or third opinion medical certification at our expense, and we will provide further details at a later time.

**\*\*NOT APPROVED\*\***

Your FMLA Leave request is **Not Approved** for the reason that;

\_\_\_ the FMLA does not apply to your leave request and/or

\_\_\_ you have exhausted your FMLA leave entitlement in the applicable 12-month period.

**Certification of Health Care Provider for Employee's Serious Health Condition  
Family and Medical Leave Act**

**SECTION 1: For Completion by the EMPLOYER**

**INSTRUCTIONS to the EMPLOYER:** FMLA provides that an employer may require an employee seeking FMLA protections because of a need for leave due to a serious health condition to submit a medical certification issued by the employee's health care provider.

Employer name: Hastings Public Schools  
Employer contact person: Superintendent of Schools  
Employee's job title: \_\_\_\_\_  
Regular work schedule: \_\_\_\_\_  
Employee's essential job functions: \_\_\_\_\_

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Check if job description is attached.

**SECTION II: For Completion by the EMPLOYEE**

**INSTRUCTIONS to the EMPLOYEE:** Please complete Section II before giving this form to your medical provider. The FMLA permits an employer to require that you submit a timely, complete, and sufficient medical certification to support a request for FMLA leave due to your own serious health condition. If requested by your employer, your response is required to obtain or retain the benefit of FMLA protections. Failure to provide a complete and sufficient medical certification may result in a denial of your FMLA request. Your employer must give you at least 15 calendar days to return this form.

Your name:

\_\_\_\_\_

First	Middle	Last
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**SECTION III: For Completion by the HEALTH CARE PROVIDER**

**INSTRUCTIONS to the HEALTH CARE PROVIDER:** Your patient has requested leave under the FMLA. Answer, fully and completely, all applicable parts. Several questions seek a response as to the frequency or duration of a condition, treatment, etc. Your answer should be your best estimate based upon your medical knowledge, experience, and examination of the patient. Be as specific as you can; terms such as "lifetime," "unknown," or "indeterminate" may not be sufficient to determine FMLA coverage. Limit your responses to the condition for which the employee is seeking leave. Please be sure to sign the form on the last page.

Provider's name and business address:

\_\_\_\_\_  
\_\_\_\_\_

Type of practice/Medical specialty: \_\_\_\_\_

Telephone: \_\_\_\_\_ Fax: \_\_\_\_\_

**Part A. MEDICAL FACTS**

1. Approximate date condition commenced: \_\_\_\_\_

Probable duration of condition: \_\_\_\_\_

**Mark below as applicable:**

Was the patient admitted for an overnight stay in a hospital, hospice, or residential medical care facility?

No  Yes. If so, dates of admission: \_\_\_\_\_

Date(s) you treated the patient for condition: \_\_\_\_\_

Will the patient need to have treatment visits at least twice per year due to the condition?

No  Yes.

Was medication, other than over-the-counter medication, prescribed?  No  Yes.

Was the patient referred to other health care provider(s) for evaluation or treatment@\_&,\_ physical therapist)?

No  Yes. If so, state the nature of such treatments and expected duration of treatment:

\_\_\_\_\_

2. Is the medical condition pregnancy?  No  Yes. If so, expected delivery date: \_\_\_\_\_

3. Use the information provided by the employer in Section 1 to answer this question. If the employer fails to provide a list of the employee's essential functions or a job description, answer these questions based upon the employee's own description of his/her job functions.

Is the employee unable to perform any of his/her job functions due to the condition:

No  Yes

If so, identify the job functions the employee is unable to perform: \_\_\_\_\_

\_\_\_\_\_

4. Describe other relevant medical facts, if any, related to the condition for which the employee seeks leave (such medical facts may include symptoms, diagnosis, or any regimen of continuing treatment such as the use of specialized equipment):

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**Part B: AMOUNT OF LEAVE NEEDED**

5. Will the employee be incapacitated for a single continuous period of time due to his/her medical condition, including any time for treatment and recovery?  No  Yes.

If so, estimate the beginning and ending dates for the period of incapacity:

\_\_\_\_\_

6. Will the employee need to attend follow-up treatment appointments or work part-time or on a reduced schedule because of the employee's medical condition?  No  Yes.

If so, are the treatments or the reduced number of hours of work medically necessary?  
 No  Yes.

Estimate treatment schedule, if any, including the dates of any scheduled appointments and the time required for each appointment, including any recovery period:

\_\_\_\_\_

Estimate the part-time or reduced work schedule the employee needs, if any:

\_\_\_\_\_ hour(s) per day; \_\_\_\_\_ days per week from \_\_\_\_\_ through \_\_\_\_\_

7. Will the condition cause episodic flare-ups periodically preventing the employee from performing his/her job functions?  No  Yes.

Is it medically necessary for the employee to be absent from work during the flare-ups?  No  Yes. If so, explain: \_\_\_\_\_

\_\_\_\_\_

Based upon the patient's medical history and your knowledge of the medical condition, estimate the frequency of flare-ups and the duration of related incapacity that the patient may have over the next 6 months @JL. 1 episode every 3 months lasting 1-2 days):

Frequency: \_\_\_\_\_ times per \_\_\_\_\_ week(s) \_\_\_\_\_ month(s)

Duration: \_\_\_\_\_ hours or \_\_\_\_\_ day(s) per episode

**ADDITIONAL INFORMATION: IDENTIFY QUESTION NUMBER WITH YOUR ADDITIONAL ANSWER:**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_



**Certification of Health Care Provider for Family Member's Serious Health Condition  
Family and Medical Leave Act**

**SECTION I: For Completion by the EMPLOYER**

**INSTRUCTIONS to the EMPLOYER:** FMLA provides that an employer may require an employee seeking FMLA protections because of a need for leave to care for a covered family member with a serious health condition to submit a medical certification issued by the health care provider of the covered family member.

Employer name: Hastings Public Schools

Employer contact person: Superintendent

**SECTION II: For Completion by the EMPLOYEE**

**INSTRUCTIONS to the EMPLOYEE:** Please complete Section II before giving this form to your family member or his/her medical provider. The FMLA permits an employer to require that you submit a timely, complete, and sufficient medical certification to support a request for FMLA leave to care for a covered family member with a serious health condition. If requested by your employer, your response is required to obtain or retain the benefit of FMLA protections. Failure to provide a complete and sufficient medical certification may result in a denial of your FMLA request. Your employer must give you at least 15 calendar days to return this form to your employer.

Your name:

\_\_\_\_\_

First	Middle	Last
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Name of family member for whom you will provide care:

\_\_\_\_\_

First	Middle	Last
-------	--------	------

Relationship of family member to you: \_\_\_\_\_

If family member is your son or daughter, date of birth: \_\_\_\_\_

Describe care you will provide to your family member and estimate leave needed to provide care:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_  
Employee Signature

\_\_\_\_\_  
Date

**SECTION III: For Completion by the HEALTH CARE PROVIDER**

**INSTRUCTIONS to the HEALTH CARE PROVIDER:** The employee listed above has requested leave under the FMLA to care for your patient. Answer, fully and completely, all applicable parts below. Several questions seek a response as to the frequency or duration of a condition, treatment, etc. Your answer should be your best estimate based upon your medical knowledge, experience, and examination of the patient. Be as specific as you can; terms such as "lifetime," "unknown," or "indeterminate" may not be sufficient to determine FMLA coverage. Limit your responses to the condition for which the patient needs leave. Please be sure to sign the form on the last page.

Provider's name and business address:

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Type of practice/Medical specialty: \_\_\_\_\_

Telephone: , \_\_\_\_\_ / \_\_\_\_\_ Fax: , \_\_\_\_\_ / \_\_\_\_\_

**Part A. MEDICAL FACTS**

1. Approximate date condition commenced: \_\_\_\_\_

Probable duration of condition: \_\_\_\_\_

Was the patient admitted for an overnight stay in a hospital, hospice, or residential medical care facility?      No      Yes. If so, dates of admission:

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Date(s) you treated the patient for condition: \_\_\_\_\_

---

Was medication, other than over-the-counter medication, prescribed?      No      Yes.

Will the patient need to have treatment visits at least twice per year due to the condition?  
No      Yes.

Was the patient referred to other health care provider(s) for evaluation or treatment (@.g., physical therapist)?    No    Yes. If so, state the nature of such treatments and expected duration of treatment: \_\_\_\_\_

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2. Is the medical condition pregnancy?    No    Yes. If so, expected delivery date:

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3. Describe other relevant medical facts, if any, related to the condition for which the patient needs care (such medical facts may include symptoms, diagnosis, or any regiment of continuing treatment such as the use of specialized equipment):

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**Part B: AMOUNT OF CARE NEEDED**

4. Will the patient be incapacitated for a single continuous period of time, including any time for treatment and recovery?  No  Yes.

Estimate the beginning and ending dates for the period of incapacity: \_\_\_\_\_

During this time, will the patient need care?  **No**  Yes.

Explain the care needed by the patient and why such care is medically necessary:

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5. Will the patient require follow-up treatment, including any time for recovery?  Yes.  No

Estimate treatment schedule, if any, including the dates of any scheduled appointments and the time required for each appointment, including any recovery period:

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Explain the care needed by the patient, and why such care is medically necessary:

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6. Will the patient require care on an intermittent or reduced schedule basis, including any time for recovery?  No  Yes.

Estimate the hours the patient needs care on an intermittent basis, if any:

\_\_\_\_\_ hour(s) per day; \_\_\_\_\_ days per week from \_\_\_\_\_ through \_\_\_\_\_

Explain the care needed by the patient, and why such care is medically necessary:

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---

7. Will the conditions cause episodic flare-ups periodically preventing the patient from participating in normal daily activities?  No  Yes.

Based upon the patient's medical history and your knowledge of the medical condition, estimate the frequency of flare-ups and the duration of related incapacity that the patient may have over the next 6 **months** (episode every 3 months lasting 1-2 days):

Frequency: \_\_\_ times per \_\_\_ week(s) \_\_\_ month(s)

Duration: \_\_\_ hours or \_\_\_ day(s) per episode

Does the patient need care during these flare-ups?  No  Yes.

Explain the care needed by the patient, and why such care is medically necessary:

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## Certification of Qualifying Exigency for Military Family Leave Family and Medical Leave Act

### SECTION I: For Completion by the EMPLOYER

**INSTRUCTIONS to the EMPLOYER:** The Family and Medical Leave Act (FMLA) provides that an employer may require an employee seeking FMLA leave due to a qualifying exigency to submit a certification. Please complete Section I before giving this form to your employee. Your response is voluntary, and while you are not required to use this form, you may not ask the employee to provide more information than allowed under the FMLA regulations, 29 CFR 825.309.

Employer Name: Hastings Public Schools

Contact Information: Superintendent

### SECTION II: For Completion by the EMPLOYEE

**INSTRUCTIONS to the EMPLOYEE:** Please complete Section II fully and completely. The FMLA permits an employer to require that you submit a timely, complete, and sufficient certification to support a request for FMLA leave due to a qualifying exigency. Several questions in this section seek a response as to the frequency or duration of the qualifying exigency. Be as specific as you can; terms such as "unknown" or "indeterminate" may not be sufficient to determine FMLA coverage. Your response is required to obtain a benefit. 29 CFR 825.310. While you are not required to provide this information, failure to do so may result in a denial of your request for FMLA leave. Your employer must give you at least 15 calendar days to return this form to your employer.

Your name:

\_\_\_\_\_

First	Middle	Last
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Name of military member on covered active duty or call to covered active duty status:

\_\_\_\_\_

First	Middle	Last
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Relationship of military member to you: \_\_\_\_\_

Period of military member's covered active duty: \_\_\_\_\_

A complete and sufficient certification to support a request for FMLA leave due to a qualifying exigency includes written documentation confirming a covered military member's active duty or call to covered active duty status. Please check one of the following and attach the indicated document to support that the military member is on covered active duty or call to covered active duty status:

\_\_\_\_\_ A copy of the military member's covered active duty orders is attached.

\_\_\_\_\_ Other documentation from the military certifying that the military member is on covered active duty (or has been notified of an impending call to

covered active duty) is attached.

\_\_\_\_\_ I have previously provided my employer with sufficient written documentation confirming the military member's covered active duty or call to covered active duty status.

**Part A. QUALIFYING REASON FOR LEAVE**

1. Describe the reason you are requesting FMLA leave due to a qualifying exigency (including the specific reason you are requesting leave):

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2. A complete and sufficient certification to support a request for FMLA leave due to a qualifying exigency includes any available written documentation which supports the need for leave; such documentation may include a copy of a meeting announcement for informational briefings sponsored by the military; a document confirming the military member's Rest and Recuperation leave; a document confirming an appointment with a third party, such as a counselor or school official, or staff at a care facility; or a copy of a bill for services for the handling of legal or financial affairs. Available written documentation supporting this request for leave is attached. Yes No None Available.

**Part 8: AMOUNT OF LEAVE NEEDED**

1. Approximate date exigency commenced: \_\_\_\_\_  
Probable duration of exigency: \_\_\_\_\_

2. Will you need to be absent from work for a single continuous period of time due to the qualifying exigency? \_ No \_ Yes.

If so, estimate the beginning and ending dales for the period of absence:

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3. Will you need to be absent from work periodically to address this qualifying exigency?  
No Yes.

Estimate schedule of leave, including the dates of any scheduling meetings or appointments:

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Estimate the frequency and duration of each appointment, meeting, or leave event, including any travel time ( . 1 deployment-related meeting every month lasting 4 hours):

Frequency: \_\_\_\_\_ times per \_\_\_\_\_ week(s) \_\_\_\_\_ month(s).

Duration: \_\_\_\_\_ hours \_\_\_\_\_ day(s) per event.

**Part C:** If leave is requested to meet with a third party (such as to arrange for childcare or parental care, to attend counseling, to attend meetings with school or childcare or parental care providers, to make financial or legal arrangements, to act as the military member's representative before a federal, state, or local agency for purposes of obtaining, arranging or appealing military service benefits, or to attend any event sponsored by the military or military service organizations), a complete and sufficient certification includes the name, address, and appropriate contact information of the individual or entity with whom you are meeting (i.e., either the telephone or fax number or email address of the individual or entity). This information may be used by your employer to verify that the information contained on this form is accurate.

Name of Individual: \_\_\_\_\_ Title: \_\_\_\_\_

Organization: \_\_\_\_\_

Address: \_\_\_\_\_

Telephone: (<1... ) \_\_\_\_\_ Fax: ('- \_\_\_\_\_ , \_\_\_\_\_

**Email** -----

Describe nature of meeting:

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**PART D:** I certify that the information I provided above is true and correct.

\_\_\_\_\_  
**Signature of Employee**

\_\_\_\_\_  
**Date**

**Certification for Serious Injury or  
Illness of a Current  
Servicemember - -for Military Family Leave  
(Family and Medical Leave Act)**

Policy 404.10  
Attachment G  
**U.S. Department of Labor**  
Wage and Hour Division

**SWHD**

U.S. Wage and Hour Division

OMB Control Number: 1235-0003

Expires: 2/28/2015

**Notice to the EMPLOYER**

**INSTRUCTIONS to the EMPLOYER:** The Family and Medical Leave Act (FMLA) provides that an employer may require an employee seeking FMLA leave due to a serious injury or illness of a current servicemember to submit a certification providing sufficient facts to support the request for leave. Your response is voluntary. While you are not required to use this form, you may not ask the employee to provide more information than allowed under the FMLA regulations, 29 CFR 825.310. Employers must generally maintain records and documents relating to medical certifications, recertifications, or medical histories of employees or employees' family members created for FMLA purposes as confidential medical records in separate files/records from the usual personnel files and in accordance with 29 CFR 1630.14(c)(1), if the Americans with Disabilities Act applies.

**SECTION II: For Completion by a UNITED STATES DEPARTMENT OF DEFENSE ("DOD") HEALTH CARE PROVIDER or a HEALTH CARE PROVIDER who is either: (1) a United States Department of Veterans Affairs ("VA") health care provider; (2) a DOD TRICARE network authorized private health care provider; (3) a DOD non-network TRICARE authorized private health care provider; or (4) a health care provider as defined in 29 CFR 825.125**

**INSTRUCTIONS to the EMPLOYEE or CURRENT SERVICEMEMBER:** Please complete Section I before having Section II completed. The FMLA permits an employer to require that an employee submit a timely, complete, and sufficient certification to support a request for FMLA leave due to a serious injury or illness of a servicemember. If requested by the employer, your response is required to obtain or retain the benefit of FMLA-protected leave. 29 U.S.C. 2613, 2614(c)(3), Failure to do so may result in a denial of an employee's FMLA request. 29 CFR 825.310(t). The employer must give an employee at least 15 calendar days to return this form to the employer.

**SECTION II: For Completion by a UNITED STATES DEPARTMENT OF DEFENSE ("DOD") HEALTH CARE PROVIDER or a HEALTH CARE PROVIDER who is either: (1) a United States Department of Veterans Affairs ("VA") health care provider; (2) a DOD TRICARE network authorized private health care provider; (3) a DOD non-network TRICARE authorized private health care provider; or (4) a health care provider as defined in 29 CFR 825.125**

**INSTRUCTIONS to the HEALTH CARE PROVIDER:** The employee listed on Page 2 has requested leave under the FMLA to care for a family member who is a current member of the Regular Armed Forces, the National Guard, or the Reserves who is undergoing medical treatment, recuperation, or therapy, is otherwise in outpatient status, or is otherwise on the temporary disability retired list for a serious injury or illness. For purposes of FMLA leave, a serious injury or illness is one that was incurred in the line of duty on active duty in the Armed Forces or that existed before the beginning of the member's active duty and was aggravated by service in the line of duty on active duty in the Armed Forces that may render the servicemember medically unfit to perform the duties of his or her office, grade, rank, or rating.

A complete and sufficient certification to support a request for FMLA leave due to a current servicemember's serious injury or illness includes written documentation confirming that the servicemember's injury or illness was incurred in the line of duty on active duty or if not, that the current servicemember's injury or illness existed before the beginning of the servicemember's active duty and was aggravated by service in the line of duty on active duty in the Armed Forces, and that the current servicemember is undergoing treatment for such injury or illness by a health care provider listed above. Answer, fully and completely, all applicable parts. Several questions seek a response as to the frequency or duration of a condition, treatment, etc. Your answer should be your best estimate based upon your medical knowledge, experience, and examination of the patient. Be as specific as you can; terms such as "lifetime," "unknown," or "indeterminate" may not be sufficient to determine FMLA coverage. Limit your responses to the servicemember's condition for which the employee is seeking leave.

**SECTION I: For Completion by the EMPLOYEE and/or the CURRENT SERVICEMEMBER for whom the Employee Is Requesting Leave:**

(This section must be completed first before any of the below sections can be completed by a health care provider.)

Name and Address of Employer (this is the employer of the employee requesting leave to care for the current servicemember):

\_\_\_\_\_  
Name of Employee Requesting Leave to Care for the Current Servicemember:

\_\_\_\_\_  
Name of the Current Servicemember (for whom employee is requesting leave to care):

\_\_\_\_\_  
Relationship of Employee to the Current Servicemember:

Spouse  Parent  Son  Daughter  Next of Kin

\_\_\_\_\_  
Part B: SERVICEMEMBER INFORMATION

(1) Is the Servicemember a Current Member of the Regular Armed Forces, the National Guard or Reserves?

Yes  No

If yes, please provide the servicemember's military branch, rank and unit currently assigned to:

\_\_\_\_\_  
Is the servicemember assigned to a military medical treatment facility as an outpatient or to a unit established for the purpose of providing command and control of members of the Armed Forces receiving medical care as outpatients (such as a medical hold or warrior transition unit)?

Yes  No

If yes, please provide the name of the medical treatment facility or unit:

\_\_\_\_\_  
(2) Is the Servicemember on the Temporary Disability Retired List (TDRL)?

Yes  No

**Part C: CARE TO BE PROVIDED TO THE SERVICEMEMBER**

Describe the Care to Be Provided to the Current Servicemember and an Estimate of the Leave Needed to Provide the Care:

\_\_\_\_\_  
\_\_\_\_\_

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625. 125; If you are unable to make certain of the military-related determinations contained below in Part B, you are permitted to rely upon determinations from an authorized DOD representative (such as a DOD recovery care coordinator).

(Please ensure that Section I above has been completed before completing this section. Please be sure to sign the form on the last page.)

**Part A: HEALTH CARE PROVIDER INFORMATION**

Health Care Provider's Name and Business Address:

\_\_\_\_\_

Type of Practice/Medical Specialty: \_\_\_\_\_

Please state whether you are either: (1) a DOD health care provider; (2) a VA health care provider; (3) a DOD TRICARE network authorized private health care provider; (4) a DOD non-network TRICARE authorized private health care provider, or (5) a health care provider as defined in 29 CFR 825.125:

\_\_\_\_\_

Telephone: ( ) \_\_\_\_\_ Fax: ( ) \_\_\_\_\_ Email: \_\_\_\_\_

**PM: f.1Bi MEDIP S.F 'IJS**

(1) The current Servicemember's medical condition is classified as (Check One of the Appropriate Boxes):

**D (VSI) Very Seriously Ill/Injured** - Illness/Injury is of such a severity that life is imminently endangered. Family members are requested at bedside immediately. (Please note this is an internal DOD casualty assistance designation used by DOD healthcare providers.)

**D (SI) Seriously Ill/Injured** - Illness/injury is of such severity that there is cause for immediate concern, but there is no imminent danger to life. Family members are requested at bedside. (Please note this is an internal DOD casualty assistance designation used by DOD healthcare providers.)

**D OTHER Ill/Injred** - a serious injury or illness that may render the servicemember medically unfit to perform the duties of the member's office, grade, rank, or rating.

**D NONE OF THE ABOVE** (Note to Employee: If this box is checked, you may still be eligible to take leave to care for a covered family member with a "serious health condition" under § 825.113 of the FMLA. If such leave is requested, you may be required to complete DOL FORM WH-380-F or an employer-provided form seeking the same information.)

(2) Is the current Servicemember being treated for a condition which was incurred or aggravated by service in the line of duty on active duty in the Armed Forces? YesD NoO

(3) Approximate date condition commenced: \_\_\_\_\_

(4) Probable duration of condition and/or need for care: \_\_\_\_\_

(5) Is the servicemember undergoing medical treatment, recuperation, or therapy for this condition? YesD NoD

If yes, please describe medical treatment, recuperation or therapy:

\_\_\_\_\_

**PART C: SERVICEMEMBER'S NEED FOR CARE BY FAMILY MEMBER**

(1) Will the servicemember need care for a single continuous period of time, including any time for treatment and recovery? YesD NoD

If yes, estimate the beginning and ending dates for this period of time: \_\_\_\_\_

(2) Will the servicemember require periodic follow-up treatment appointments? YesD No

If yes, estimate the treatment schedule: \_\_\_\_\_

(3) Is there a medical necessity for the servicemember to have periodic care for these follow-up treatment appointments? YesD NoD

(4) Is there a medical necessity for the servicemember to have periodic care for other than scheduled follow-up treatment appointments (e.g., episodic flare-ups of medical condition)?

YesD No

If yes, please estimate the frequency and duration of the periodic care:

\_\_\_\_\_

\_\_\_\_\_

**Signature of Health Care Provider:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**PAPERWORK REDUCTION ACT NOTICE AND PUBLIC BURDEN STATEMENT**

If submitted, it is mandatory for employers to retain a copy of this disclosure in their records for three years, in accordance with 29 U.S.C. 2616; 29 CFR 825.500. Persons are not required to respond to this collection of information unless it displays a currently valid OMB control number. The Department of Labor estimates that it will take an average of 20 minutes for respondents to complete this collection of information, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. If you have any comments regarding this burden estimate or any other aspect of this collection information, including suggestions for reducing this burden, send them to the Administrator, Wage and Hour Division, U.S. Department of Labor, Room S 3502, 200 Constitution AV, NW, Washington, DC 20210. **DO NOT SEND THE COMPLETED FORM TO THE WAGE AND HOUR DIVISION; RETURN IT TO THE PATIENT.**

## **FAMILY AND MEDICAL LEAVE – ALL EMPLOYEES**

Family and medical leaves shall be allowed under the terms and conditions of the Family and Medical Leave Act of 1993 (FMLA) as amended.

The “leave year” for purposes of the FMLA shall be a “rolling” twelve-month period, measured backward from the date of any FMLA leave usage.

Substitution of accrued paid leaves for otherwise unpaid FMLA leaves will be required. The employee will have paid leave run concurrently with unpaid FMLA leave entitlement, provided the employee meets applicable requirements of the leave policy.

Employees shall be required to submit medical certifications to support a request for FMLA leave because of a serious health condition, or a sick leave, when such leave is for a duration in excess of five (5) successive days, and in such other cases as deemed appropriate by the Superintendent or the Board based on the nature of the illness or other circumstances surrounding the leave. Second and third medical opinions may, in the Superintendent or the Board's discretion, be required. Employees shall be required to report periodically, at such times as requested by the Superintendent or the Board, on their intent to return to work from FMLA leaves and other leaves. Employees shall be required to submit a fitness-for-duty certification from their health care provider as a condition of returning to work from a FMLA leave taken because of the employee's serious health condition, or from a sick leave taken by reason of the employee's illness, when such leave was of a duration in excess of five (5) successive days, and upon request of the Superintendent or the Board when such is deemed appropriate by the Superintendent or the Board based upon the nature of the illness or other circumstances surrounding the leave.

An "equivalent position" for FMLA restoration purposes shall, in the case of certificated employees, be any administrative, teaching, or instruction related position for which the employee is qualified by reason of endorsement, college preparation, experience, or other indicia; in the case of coaching or other similar extracurricular duty assignments, be any extracurricular duty assignment, and in the case of other employees or positions, be in a position with or at equivalent pay, benefits, and working conditions, involving similar or related duties, as determined by the Superintendent or the Board.

The documents provided in response to the Family Medical Leave Act (FMLA) regulations are:

1. FMLA Leave Application
2. Notice of Eligibility and Rights and Responsibilities - Rolling Year
3. Designation Notice
4. Certification of Health Care Provider for Employee's Serious Health Condition
5. Certification of Health Care Provider for Family Member's Serious Health Condition
6. Certification of Qualifying Exigency for Military Family Leave
7. Family Military Leave Certification for Serious Injury of Service member

Legal Reference: 29 USC§§ 2611 to 2618 and 29 CFR Part 82

Approved: 09/18/2017      Reviewed: 07/12/2021      Revised: 07/12/2021

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**Application for Leave  
Family and Medical Leave Act**

Employee Name: \_\_\_\_\_ Title/Position: \_\_\_\_\_

Building/Dept: \_\_\_\_\_ Supervisor: \_\_\_\_\_

Hire Date: \_\_\_\_\_

**FMLA Leave Requested** From Date: \_\_\_\_\_ Return Date: \_\_\_\_\_

If leave is requested on an intermittent or reduced leave schedule, describe the requested leave schedule: \_\_\_\_\_

**Reason for Leave Request** (check and complete as appropriate):

\_\_\_\_\_ 1. For birth of a son or daughter, and to care for the newborn child.  
Expected date of birth: \_\_\_\_\_ Actual date of birth: \_\_\_\_\_

\_\_\_\_\_ 2. For placement, with the employee, of a son or daughter for adoption or foster care. Date of placement: \_\_\_\_\_

\_\_\_\_\_ 3. To care for the employee's spouse, son or daughter, or parent with a serious health condition.  
Name and relationship of family member: \_\_\_\_\_  
Describe reason employee needs to provide the care and the nature of the care: \_\_\_\_\_

\_\_\_\_\_ 4. Because of a serious health condition that makes the employee unable to perform the functions of the employee's job.  
Briefly describe condition and job functions that employee is unable to perform: \_\_\_\_\_

\_\_\_\_\_ 5. Because of a qualifying exigency arising out of the fact that the employee's spouse, son or daughter, or parent is a covered military member on active duty (or has been notified of an impending call or order to active duty) in support of a contingency operation.  
Name and relationship of family member: \_\_\_\_\_  
Describe the qualifying exigency: \_\_\_\_\_

\_\_\_\_\_ 6. To care for a covered service member with a serious injury or illness if the employee is the spouse, son, daughter, parent, or next of kin of the service member.  
Name and relationship of family member: \_\_\_\_\_  
Describe reason employee needs to provide the care and the nature of the care: \_\_\_\_\_

I certify that the above information given by me is correct and that I have read the foregoing and understand my rights under the FMLA.

Employee's signature: \_\_\_\_\_ Date: \_\_\_\_\_

**Notice of Eligibility & Rights and Responsibilities  
under the Family and Medical Leave Act**

**U.S. Department of Labor  
Wage and Hour Division**



**DO NOT SEND TO THE DEPARTMENT OF LABOR.  
PROVIDE TO EMPLOYEE.**

OMB Control Number: 1235-0003  
Expires: 6/30/2023

In general, to be eligible to take leave under the Family and Medical Leave Act (FMLA), an employee must have worked for an employer for at least 12 months, meet the hours of service requirement in the 12 months preceding the leave, and work at a site with at least 50 employees within 75 miles. While use of this form is optional, a fully completed Form WH-381 provides employees with the information required by 29 C.F.R. §§ 825.300(b), (c) which must be provided within five business days of the employee notifying the employer of the need for FMLA leave. Information about the FMLA may be found [on the WHD website at www.dol.gov/agencies/whd/fmla](http://www.dol.gov/agencies/whd/fmla).

Date: \_\_\_\_\_ (mm/dd/yyyy)

From: \_\_\_\_\_ (Employer) To: \_\_\_\_\_ (Employee)

On \_\_\_\_\_ (mm/dd/yyyy), we learned that you need leave (beginning on) \_\_\_\_\_ (mm/dd/yyyy) for one of the following reasons: (Select as appropriate)

- The birth of a child, or placement of a child with you for adoption or foster care, and to bond with the newborn or newly-placed child
- Your own serious health condition
- You are needed to care for your family member due to a serious health condition. Your family member is your:
  - Spouse                       Parent                       Child under age 18       Child 18 years or older and incapable of self-care because of a mental or physical disability
- A qualifying exigency arising out of the fact that your family member is on covered active duty or has been notified of an impending call or order to covered active duty status. Your family member on covered active duty is your:
  - Spouse                       Parent                       Child of any age
- You are needed to care for your family member who is a covered servicemember with a serious injury or illness. You are the servicemember's:
  - Spouse                       Parent                       Child                       Next of kin

Spouse means a husband or wife as defined or recognized in the state where the individual was married, including in a common law marriage or same-sex marriage. The terms "child" and "parent" include *in loco parentis* relationships in which a person assumes the obligations of a parent to a child. An employee may take FMLA leave to care for an individual who assumed the obligations of a parent to the employee when the employee was a child. An employee may also take FMLA leave to care for a child for whom the employee has assumed the obligations of a parent. No legal or biological relationship is necessary.

**SECTION I – NOTICE OF ELIGIBILITY**

**This Notice is to inform you that you are:**

- Eligible** for FMLA leave. (See Section II for any Additional Information Needed and Section III for information on your Rights and Responsibilities.)
- Not eligible** for FMLA leave because: (Only one reason need be checked)
  - You have not met the FMLA's 12-month length of service requirement. As of the first date of requested leave, you will have worked approximately: \_\_\_\_\_ towards this requirement.  
(months)
  - You have not met the FMLA's 1,250 hours of service requirement. As of the first date of requested leave, you will have worked approximately: \_\_\_\_\_ towards this requirement.  
(hours of service)

Employee Name: \_\_\_\_\_

- You are an airline flight crew employee and you have not met the special hours of service eligibility requirements for airline flight crew employees as of the first date of requested leave (i.e., worked or been paid for at least 60% of your applicable monthly guarantee, and worked or been paid for at least 504 duty hours.)
- You do not work at and/or report to a site with 50 or more employees within 75-miles as of the date of your request.

If you have any questions, please contact: \_\_\_\_\_ (Name of employer representative)  
at \_\_\_\_\_ (Contact information).

## SECTION II – ADDITIONAL INFORMATION NEEDED

As explained in Section I, you meet the eligibility requirements for taking FMLA leave. Please review the information below to determine if additional information is needed in order for us to determine whether your absence qualifies as FMLA leave. Once we obtain any additional information specified below we will inform you, **within 5 business days**, whether your leave will be designated as FMLA leave and count towards the FMLA leave you have available. **If complete and sufficient information is not provided in a timely manner, your leave may be denied.**

(Select as appropriate)

- No additional information requested. If no additional information requested, go to Section III.
- We request that the leave be supported by a certification, as identified below.
  - Health Care Provider for the Employee
  - Health Care Provider for the Employee's Family Member
  - Qualifying Exigency
  - Serious Illness or Injury (Military Caregiver Leave)

Selected certification form is  attached /  not attached.

If requested, medical certification must be returned by \_\_\_\_\_ (mm/dd/yyyy) (Must allow at least 15 calendar days from the date the employer requested the employee to provide certification, unless it is not feasible despite the employee's diligent, good faith efforts.)

- We request that you provide reasonable documentation or a statement to establish the relationship between you and your family member, including *in loco parentis* relationships (as explained on page one). The information requested must be returned to us by \_\_\_\_\_ (mm/dd/yyyy). You may choose to provide a simple statement of the relationship or provide documentation such as a child's birth certificate, a court document, or documents regarding foster care or adoption-related activities. Official documents submitted for this purpose will be returned to you after examination.

- Other information needed (e.g. documentation for military family leave): \_\_\_\_\_  
The information requested must be returned to us by \_\_\_\_\_ (mm/dd/yyyy).

If you have any questions, please contact: \_\_\_\_\_ (Name of employer representative)  
at \_\_\_\_\_ (Contact information).

## SECTION III – NOTICE OF RIGHTS AND RESPONSIBILITIES

### **Part A: FMLA Leave Entitlement**

You have a right under the FMLA to take unpaid, job-protected FMLA leave in a 12-month period for certain family and medical reasons, including up to **12 weeks** of unpaid leave in a 12-month period for the birth of a child or placement of a child for adoption or foster care, for leave related to your own or a family member's serious health condition, or for certain qualifying exigencies related to the deployment of a military member to covered active duty. You also have a right

Employee Name: \_\_\_\_\_

under the FMLA to take up to **26 weeks** of unpaid, job-protected FMLA leave in a single 12-month period to care for a covered servicemember with a serious injury or illness (*Military Caregiver Leave*).

The 12-month period for FMLA leave is calculated as: (*Select as appropriate*)

- The calendar year (January 1<sup>st</sup> - December 31<sup>st</sup>)
- A fixed leave year based on \_\_\_\_\_  
(*e.g., a fiscal year beginning on July 1 and ending on June 30*)
- The 12-month period measured forward from the date of your first FMLA leave usage.
- A “rolling” 12-month period measured backward from the date of any FMLA leave usage. (*Each time an employee takes FMLA leave, the remaining leave is the balance of the 12 weeks not used during the 12 months immediately before the FMLA leave is to start.*)

If applicable, the single 12-month period for *Military Caregiver Leave* started on \_\_\_\_\_ (*mm/dd/yyyy*).

**You** ( *are* /  *are not*) **considered a key employee** as defined under the FMLA. Your FMLA leave cannot be denied for this reason; however, we may not restore you to employment following FMLA leave if such restoration will cause substantial and grievous economic injury to us.

We ( *have* /  *have not*) determined that restoring you to employment at the conclusion of FMLA leave will cause substantial and grievous economic harm to us. Additional information will be provided separately concerning your status as key employee and restoration.

**Part B: Substitution of Paid Leave – When Paid Leave is Used at the Same Time as FMLA Leave**

You have a right under the FMLA to request that your accrued paid leave be substituted for your FMLA leave. This means that you can request that your accrued paid leave run concurrently with some or all of your unpaid FMLA leave, provided you meet any applicable requirements of our leave policy. Concurrent leave use means the absence will count against both the designated paid leave and unpaid FMLA leave at the same time. If you do not meet the requirements for taking paid leave, you remain entitled to take available unpaid FMLA leave in the applicable 12-month period. Even if you do not request it, the FMLA allows us to require you to use your available sick, vacation, or other paid leave during your FMLA absence.

(*Check all that apply*)

- Some or all of your FMLA leave will not be paid.** Any unpaid FMLA leave taken will be designated as FMLA leave and counted against the amount of FMLA leave you have available to use in the applicable 12-month period.
- You have requested to use some or all of your available paid leave** (*e.g., sick, vacation, PTO*) during your FMLA leave. Any paid leave taken for this reason will also be designated as FMLA leave and counted against the amount of FMLA leave you have available to use in the applicable 12-month period.
- We are requiring you to use some or all of your available paid leave** (*e.g., sick, vacation, PTO*) during your FMLA leave. Any paid leave taken for this reason will also be designated as FMLA leave and counted against the amount of FMLA leave you have available to use in the applicable 12-month period.
- Other:** (*e.g., short- or long-term disability, workers’ compensation, state medical leave law, etc.*) \_\_\_\_\_  
Any time taken for this reason will also be designated as FMLA leave and counted against the amount of FMLA leave you have available to use in the applicable 12-month period.

The applicable conditions for use of paid leave include: \_\_\_\_\_.

For more information about conditions applicable to sick/vacation/other paid leave usage please refer to \_\_\_\_\_  
\_\_\_\_\_ available at: \_\_\_\_\_.

Employee Name: \_\_\_\_\_

**Part C: Maintain Health Benefits**

Your health benefits must be maintained during any period of FMLA leave under the same conditions as if you continued to work. During any paid portion of FMLA leave, your share of any premiums will be paid by the method normally used during any paid leave. During any unpaid portion of FMLA leave, you must continue to make any normal contributions to the cost of the health insurance premiums. To make arrangements to continue to make your share of the premium payments on your health insurance while you are on any unpaid FMLA leave, contact \_\_\_\_\_ at \_\_\_\_\_.

You have a minimum grace period of ( 30-days or  \_\_\_\_\_ *indicate longer period, if applicable*) in which to make premium payments. If payment is not made timely, your group health insurance may be cancelled, provided we notify you in writing at least 15 days before the date that your health coverage will lapse, or, at our option, we may pay your share of the premiums during FMLA leave, and recover these payments from you upon your return to work.

You may be required to reimburse us for our share of health insurance premiums paid on your behalf during your FMLA leave if you do not return to work following **unpaid** FMLA leave for a reason other than: the continuation, recurrence, or onset of your or your family member's serious health condition which would entitle you to FMLA leave; or the continuation, recurrence, or onset of a covered servicemember's serious injury or illness which would entitle you to FMLA leave; or other circumstances beyond your control.

**Part D: Other Employee Benefits**

Upon your return from FMLA leave, your other employee benefits, such as pensions or life insurance, must be resumed in the same manner and at the same levels as provided when your FMLA leave began. To make arrangements to continue your employee benefits while you are on FMLA leave, contact \_\_\_\_\_ at \_\_\_\_\_.

**Part E: Return-to-Work Requirements**

You must be reinstated to the same or an equivalent job with the same pay, benefits, and terms and conditions of employment on your return from FMLA-protected leave. An equivalent position is one that is virtually identical to your former position in terms of pay, benefits, and working conditions. At the end of your FMLA leave, all benefits must also be resumed in the same manner and at the same level provided when the leave began. You do not have return-to-work rights under the FMLA if you need leave beyond the amount of FMLA leave you have available to use.

**Part F: Other Requirements While on FMLA Leave**

While on leave you ( will be /  will not be) required to furnish us with periodic reports of your status and intent to return to work every \_\_\_\_\_.

*(Indicate interval of periodic reports, as appropriate for the FMLA leave situation).*

**If the circumstances of your leave change and you are able to return to work earlier than expected, you will be required to notify us at least two workdays prior to the date you intend to report for work.**

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**PAPERWORK REDUCTION ACT NOTICE AND PUBLIC BURDEN STATEMENT**

It is mandatory for employers to provide employees with notice of their eligibility for FMLA protection and their rights and responsibilities. 29 U.S.C. § 2617; 29 C.F.R. § 825.300(b), (c). It is mandatory for employers to retain a copy of this disclosure in their records for three years. 29 U.S.C. § 2616; 29 C.F.R. § 825.500. Persons are not required to respond to this collection of information unless it displays a currently valid OMB control number. The Department of Labor estimates that it will take an average of 10 minutes for respondents to complete this collection of information, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. If you have any comments regarding this burden estimate or any other aspect of this collection information, including suggestions for reducing this burden, send them to the Administrator, Wage and Hour Division, U.S. Department of Labor, Room S-3502, 200 Constitution Avenue, N.W., Washington, D.C. 20210.

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**DO NOT SEND THE COMPLETED FORM TO THE DEPARTMENT OF LABOR. EMPLOYEE INFORMATION.**

**Designation Notice  
under the Family and Medical Leave Act****U.S. Department of Labor  
Wage and Hour Division****DO NOT SEND TO THE DEPARTMENT OF LABOR.  
PROVIDE TO EMPLOYEE.**

OMB Control Number: 1235-0003

Expires: 6/30/2023

Leave covered under the Family and Medical Leave Act (FMLA) must be designated as FMLA-protected and the employer must inform the employee of the amount of leave that will be counted against the employee's FMLA leave entitlement. In order to determine whether leave is covered under the FMLA, the employer may request that the leave be supported by a certification. If the certification is incomplete or insufficient, the employer must state in writing what additional information is necessary to make the certification complete and sufficient. While use of this form is optional, a fully completed Form WH-382 provides employees with the information required by 29 C.F.R. §§ 825.300(d), 825.301, and 825.305(c), which must be provided within five business days of the employer having enough information to determine whether the leave is for an FMLA-qualifying reason. Information about the FMLA may be found [on the WHD website at www.dol.gov/agencies/whd/fmla](http://www.dol.gov/agencies/whd/fmla).

**SECTION I - EMPLOYER**

The employer is responsible in **all** circumstances for designating leave as FMLA-qualifying and giving notice to the employee. Once an eligible employee communicates a need to take leave for an FMLA-qualifying reason, an employer may not delay designating such leave as FMLA leave, and neither the employee nor the employer may decline FMLA protection for that leave.

Date: \_\_\_\_\_ (mm/dd/yyyy)

From: \_\_\_\_\_ (Employer) To: \_\_\_\_\_ (Employee)

On \_\_\_\_\_ (mm/dd/yyyy) we received your most recent information to support your need for leave due to:  
(Select as appropriate)

- The birth of a child, or placement of a child with you for adoption or foster care, and to bond with the newborn or newly-placed child
- Your own serious health condition
- The serious health condition of your spouse, child, or parent
- A qualifying exigency arising out of the fact that your spouse, child, or parent is on covered active duty or has been notified of an impending call or order to covered active duty with the Armed Forces
- A serious injury or illness of a covered servicemember where you are the servicemember's spouse, child, parent, or next of kin (*Military Caregiver Leave*)

**We have reviewed information related to your need for leave under the FMLA along with any supporting documentation provided and decided that your FMLA leave request is:** (Select as appropriate)

- Approved.** All leave taken for this reason will be designated as FMLA leave. Go to Section III for more information.
- Not Approved:** (Select as appropriate)
  - The FMLA does not apply to your leave request.
  - As of the date the leave is to start, you do not have any FMLA leave available to use.
  - Other \_\_\_\_\_
- Additional information** is needed to determine if your leave request qualifies as FMLA leave. (*Go to Section II for the specific information needed. If your FMLA leave request is approved and no additional information is needed, go to Section III.*)

**SECTION II – ADDITIONAL INFORMATION NEEDED**

We need additional information to determine whether your leave request qualifies under the FMLA. Once we obtain the additional information requested, we will inform you **within 5 business days** if your leave will or will not be designated as FMLA leave and count towards the amount of FMLA leave you have available. **Failure to provide the additional information as requested may result in a denial of your FMLA leave request.**

If you have any questions, please contact: \_\_\_\_\_ at \_\_\_\_\_  
(Name of employer FMLA representative) (Contact information)

**Incomplete or Insufficient Certification**

The certification you have provided is incomplete and/or insufficient to determine whether the FMLA applies to your leave request.  
(Select as applicable)

- The certification provided is incomplete and we are unable to determine whether the FMLA applies to your leave request. "*Incomplete*" means one or more of the applicable entries on the certification have not been completed.

Employee Name: \_\_\_\_\_

- The certification provided is insufficient to determine whether the FMLA applies to your leave request. “Insufficient” means the information provided is vague, unclear, ambiguous or non-responsive.

Specify the information needed to make the certification complete and/or sufficient: \_\_\_\_\_

You must provide the requested information no later than (provide at least 7 calendar days) \_\_\_\_\_ (mm/dd/yyyy), unless it is not practicable under the particular circumstances despite your diligent good faith efforts, or your leave may be denied.

### Second and Third Opinions

- We request that you obtain a ( second /  third opinion) medical certification at our expense, and we will provide further details at a later time. *Note: The employee or the employee’s family member may be requested to authorize the health care provider to release information pertaining only to the serious health condition at issue.*

## SECTION III – FMLA LEAVE APPROVED

As explained in Section I, your FMLA leave request is approved. All leave taken for this reason will be designated as FMLA leave and will count against the amount of FMLA leave you have available to use in the applicable 12-month period. The FMLA requires that you notify us as soon as practicable if the dates of scheduled leave change, are extended, or were initially unknown. Based on the information you have provided to date, we are providing the following information about the amount of time that will be counted against the total **amount of FMLA leave** you have available to use in the applicable 12-month period: *(Select as appropriate)*

- Provided there is no change from your **anticipated FMLA leave schedule**, the following number of hours, days, or weeks will be counted against your leave entitlement: \_\_\_\_\_.
- Because the leave you will need will be **unscheduled**, it is not possible to provide the hours, days, or weeks that will be counted against your FMLA entitlement at this time. You have the right to request this information once in a 30-day period (if leave was taken in the 30-day period).

Please be advised: *(check all that apply)*

- Some or all of your FMLA leave will not be paid.** Any unpaid FMLA leave taken will be designated as FMLA leave and counted against the amount of FMLA leave you have available to use in the applicable 12-month period.
- Based on your request, some or all of your available paid leave** (e.g., sick, vacation, PTO) **will be used during your FMLA leave.** Any paid leave taken for this reason will also be designated as FMLA leave and counted against the amount of FMLA leave you have available to use in the applicable 12-month period.
- We are requiring you to use some or all of your available paid leave** (e.g., sick, vacation, PTO) **during your FMLA leave.** Any paid leave taken for this reason will also be designated as FMLA leave and counted against the amount of FMLA leave you have available to use in the applicable 12-month period.
- Other:** \_\_\_\_\_  
(e.g., Short- or long-term disability, workers’ compensation, state medical leave law, etc.) Any time taken for this reason will also be designated as FMLA leave and counted against the amount of FMLA leave you have available to use in the applicable 12-month period.

**Return-to-work requirements.** To be restored to work after taking FMLA leave, you ( will be /  will not be) required to provide a certification from your health care provider (fitness-for-duty certification) that you are able to resume work. This request for a fitness-for-duty certification is *only* with regard to the particular serious health condition that caused your need for FMLA leave. **If such certification is not timely received, your return to work may be delayed until the certification is provided.**

A list of the essential functions of your position ( is /  is not) attached. If attached, the fitness-for-duty certification must address your ability to perform the essential job functions.

### PAPERWORK REDUCTION ACT NOTICE AND PUBLIC BURDEN STATEMENT

It is mandatory for employers to inform employees in writing whether leave requested under the FMLA has been determined to be covered under the FMLA. 29 U.S.C. § 2617; 29 C.F.R. § 825.300(d), (e). It is mandatory for employers to retain a copy of this disclosure in their records for three years. 29 U.S.C. § 2616; 29 C.F.R. § 825.500. Persons are not required to respond to this collection of information unless it displays a currently valid OMB control number. The Department of Labor estimates that it will take an average of 10 minutes for respondents to complete this collection of information, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. If you have any comments regarding this burden estimate or any other aspect of this collection information, including suggestions for reducing this burden, send them to the Administrator, Wage and Hour Division, U.S. Department of Labor, Room S-3502, 200 Constitution Avenue, N.W., Washington, D.C. 20210.

**DO NOT SEND THE COMPLETED FORM TO THE DEPARTMENT OF LABOR. EMPLOYEE INFORMATION.**

**Certification of Health Care Provider for  
Employee’s Serious Health Condition  
under the Family and Medical Leave Act**

**U.S. Department of Labor  
Wage and Hour Division**



DO NOT SEND COMPLETED FORM TO THE DEPARTMENT OF LABOR.  
RETURN TO THE PATIENT.

OMB Control Number: 1235-0003  
Expires: 6/30/2023

The Family and Medical Leave Act (FMLA) provides that an employer may require an employee seeking FMLA protections because of a need for leave due to a serious health condition to submit a medical certification issued by the employee’s health care provider. 29 U.S.C. §§ 2613, 2614(c)(3); 29 C.F.R. § 825.305. The employer must give the employee **at least 15 calendar days** to provide the certification. If the employee fails to provide complete and sufficient medical certification, his or her FMLA leave request may be denied. 29 C.F.R. § 825.313. Information about the FMLA may be found [on the WHD website at www.dol.gov/agencies/whd/fmla](http://www.dol.gov/agencies/whd/fmla).

**SECTION I – EMPLOYER**

Either the employee or the employer may complete Section I. While use of this form is optional, this form asks the health care provider for the information necessary for a complete and sufficient medical certification, which is set out at 29 C.F.R. § 825.306. **You may not ask the employee to provide more information than allowed under the FMLA regulations, 29 C.F.R. §§ 825.306-825.308.** Additionally, you **may not** request a certification for FMLA leave to bond with a healthy newborn child or a child placed for adoption or foster care.

Employers must generally maintain records and documents relating to medical information, medical certifications, recertifications, or medical histories of employees created for FMLA purposes as confidential medical records in separate files/records from the usual personnel files and in accordance with 29 C.F.R. § 1630.14(c)(1), if the Americans with Disabilities Act applies, and in accordance with 29 C.F.R. § 1635.9, if the Genetic Information Nondiscrimination Act applies.

(1) Employee name: \_\_\_\_\_  
*First*
*Middle*
*Last*

(2) Employer name: \_\_\_\_\_ Date: \_\_\_\_\_ (mm/dd/yyyy)  
*(List date certification requested)*

(3) The medical certification must be returned by \_\_\_\_\_ (mm/dd/yyyy)  
*(Must allow at least 15 calendar days from the date requested, unless it is not feasible despite the employee’s diligent, good faith efforts.)*

(4) Employee’s job title: \_\_\_\_\_ Job description (  is /  is not) attached.  
 Employee’s regular work schedule: \_\_\_\_\_  
 Statement of the employee’s essential job functions: \_\_\_\_\_

*(The essential functions of the employee’s position are determined with reference to the position the employee held at the time the employee notified the employer of the need for leave or the leave started, whichever is earlier.)*

**SECTION II - HEALTH CARE PROVIDER**

Please provide your contact information, complete all relevant parts of this Section, and sign the form. Your patient has requested leave under the FMLA. The FMLA allows an employer to require that the employee submit a timely, complete, and sufficient medical certification to support a request for FMLA leave due to the serious health condition of the employee. For FMLA purposes, a “serious health condition” means an illness, injury, impairment, or physical or mental condition that involves *inpatient care* or *continuing treatment by a health care provider*. For more information about the definitions of a serious health condition under the FMLA, see the chart on page 4.

You may, but are **not required** to, provide other appropriate medical facts including symptoms, diagnosis, or any regimen of continuing treatment such as the use of specialized equipment. Please note that some state or local laws may not allow disclosure of private medical information about the patient’s serious health condition, such as providing the diagnosis and/or course of treatment.

Employee Name: \_\_\_\_\_

Health Care Provider's name: (Print) \_\_\_\_\_

Health Care Provider's business address: \_\_\_\_\_

Type of practice / Medical specialty: \_\_\_\_\_

Telephone: (\_\_\_\_) \_\_\_\_\_ Fax: (\_\_\_\_) \_\_\_\_\_ E-mail: \_\_\_\_\_

**PART A: Medical Information**

Limit your response to the medical condition(s) for which the employee is seeking FMLA leave. Your answers should be your **best estimate** based upon your medical knowledge, experience, and examination of the patient. **After completing Part A, complete Part B to provide information about the amount of leave needed.** Note: For FMLA purposes, "incapacity" means the inability to work, attend school, or perform regular daily activities due to the condition, treatment of the condition, or recovery from the condition. Do not provide information about genetic tests, as defined in 29 C.F.R. § 1635.3(f), genetic services, as defined in 29 C.F.R. § 1635.3(e), or the manifestation of disease or disorder in the employee's family members, 29 C.F.R. § 1635.3(b).

(1) State the approximate date the condition started or will start: \_\_\_\_\_ (mm/dd/yyyy)

(2) Provide your **best estimate** of how long the condition lasted or will last: \_\_\_\_\_

(3) Check the box(es) for the questions below, as applicable. For all box(es) checked, the amount of leave needed must be provided in Part B.

**Inpatient Care**: The patient ( has been /  is expected to be) admitted for an overnight stay in a hospital, hospice, or residential medical care facility on the following date(s): \_\_\_\_\_

**Incapacity plus Treatment**: (e.g. outpatient surgery, strep throat)  
Due to the condition, the patient ( has been /  is expected to be) incapacitated for *more than* three consecutive, full calendar days from \_\_\_\_\_ (mm/dd/yyyy) to \_\_\_\_\_ (mm/dd/yyyy).

The patient ( was /  will be) seen on the following date(s): \_\_\_\_\_  
\_\_\_\_\_

The condition ( has /  has not) also resulted in a course of continuing treatment under the supervision of a health care provider (e.g. prescription medication (other than over-the-counter) or therapy requiring special equipment)

**Pregnancy**: The condition is pregnancy. List the expected delivery date: \_\_\_\_\_ (mm/dd/yyyy).

**Chronic Conditions**: (e.g. asthma, migraine headaches) Due to the condition, it is medically necessary for the patient to have treatment visits at least twice per year.

**Permanent or Long Term Conditions**: (e.g. Alzheimer's, terminal stages of cancer) Due to the condition, incapacity is permanent or long term and requires the continuing supervision of a health care provider (even if active treatment is not being provided).

**Conditions requiring Multiple Treatments**: (e.g. chemotherapy treatments, restorative surgery) Due to the condition, it is medically necessary for the patient to receive multiple treatments.

**None of the above**: If none of the above condition(s) were checked, (i.e., inpatient care, pregnancy) no additional information is needed. Go to page 4 to sign and date the form.

Employee Name: \_\_\_\_\_

- (4) If needed, briefly describe other appropriate medical facts related to the condition(s) for which the employee seeks FMLA leave. (e.g., use of nebulizer, dialysis) \_\_\_\_\_

**PART B: Amount of Leave Needed**

For the medical condition(s) checked in Part A, complete all that apply. Several questions seek a response as to the frequency or duration of a condition, treatment, etc. Your answer should be your **best estimate** based upon your medical knowledge, experience, and examination of the patient. Be as specific as you can; terms such as “lifetime,” “unknown,” or “indeterminate” may not be sufficient to determine FMLA coverage.

- (5) Due to the condition, the patient ( had /  will have) **planned medical treatment(s)** (scheduled medical visits) (e.g. psychotherapy, prenatal appointments) on the following date(s): \_\_\_\_\_

- (6) Due to the condition, the patient ( was /  will be) **referred to other health care provider(s)** for evaluation or treatment(s).

State the nature of such treatments: (e.g. cardiologist, physical therapy) \_\_\_\_\_

Provide your **best estimate** of the beginning date \_\_\_\_\_ (mm/dd/yyyy) and end date \_\_\_\_\_ (mm/dd/yyyy) for the treatment(s).

Provide your **best estimate** of the duration of the treatment(s), including any period(s) of recovery (e.g. 3 days/week) \_\_\_\_\_

- (7) Due to the condition, it is medically necessary for the employee to work a **reduced schedule**.

Provide your **best estimate** of the reduced schedule the employee is able to work. From \_\_\_\_\_ (mm/dd/yyyy) to \_\_\_\_\_ (mm/dd/yyyy) the employee is able to work: (e.g., 5 hours/day, up to 25 hours a week)

- (8) Due to the condition, the patient ( was /  will be) **incapacitated for a continuous period of time**, including any time for treatment(s) and/or recovery.

Provide your **best estimate** of the beginning date \_\_\_\_\_ (mm/dd/yyyy) and end date \_\_\_\_\_ (mm/dd/yyyy) for the period of incapacity.

- (9) Due to the condition, it ( was /  is /  will be) medically necessary for the employee to be absent from work on an **intermittent basis** (periodically), including for any episodes of incapacity i.e., episodic flare-ups. Provide your **best estimate** of how often (frequency) and how long (duration) the episodes of incapacity will likely last.

Over the next 6 months, episodes of incapacity are estimated to occur \_\_\_\_\_ times per ( day /  week /  month) and are likely to last approximately \_\_\_\_\_ (  hours /  days) per episode.

Employee Name: \_\_\_\_\_

**PART C: Essential Job Functions**

If provided, the information in Section I question #4 may be used to answer this question. If the employer fails to provide a statement of the employee’s essential functions or a job description, answer these questions based upon the employee’s own description of the essential job functions. An employee who must be absent from work to receive medical treatment(s), such as scheduled medical visits, for a serious health condition is considered to be *not able* to perform the essential job functions of the position during the absence for treatment(s).

(10) Due to the condition, the employee ( was not able /  is not able /  will not be able) to perform *one or more* of the essential job function(s). Identify at least one essential job function the employee is not able to perform:

\_\_\_\_\_  
\_\_\_\_\_

Signature of Health Care Provider \_\_\_\_\_ Date \_\_\_\_\_ (mm/dd/yyyy)

<b>Definitions of a Serious Health Condition</b> (See 29 C.F.R. §§ 825.113-.115)
<b>Inpatient Care</b>
<ul style="list-style-type: none"><li>• An overnight stay in a hospital, hospice, or residential medical care facility.</li><li>• Inpatient care includes any period of incapacity or any subsequent treatment in connection with the overnight stay.</li></ul>
<b>Continuing Treatment by a Health Care Provider (any one or more of the following)</b>
<p><b>Incapacity Plus Treatment:</b> A period of incapacity of more than three consecutive, full calendar days, and any subsequent treatment or period of incapacity relating to the same condition, that also involves either:</p> <ul style="list-style-type: none"><li>○ Two or more in-person visits to a health care provider for treatment within 30 days of the first day of incapacity unless extenuating circumstances exist. The first visit must be within seven days of the first day of incapacity; or,</li><li>○ At least one in-person visit to a health care provider for treatment within seven days of the first day of incapacity, which results in a regimen of continuing treatment under the supervision of the health care provider. For example, the health provider might prescribe a course of prescription medication or therapy requiring special equipment.</li></ul>
<p><b>Pregnancy:</b> Any period of incapacity due to pregnancy or for prenatal care.</p>
<p><b>Chronic Conditions:</b> Any period of incapacity due to or treatment for a chronic serious health condition, such as diabetes, asthma, migraine headaches. A chronic serious health condition is one which requires visits to a health care provider (or nurse supervised by the provider) at least twice a year and recurs over an extended period of time. A chronic condition may cause episodic rather than a continuing period of incapacity.</p>
<p><b>Permanent or Long-term Conditions:</b> A period of incapacity which is permanent or long-term due to a condition for which treatment may not be effective, but which requires the continuing supervision of a health care provider, such as Alzheimer’s disease or the terminal stages of cancer.</p>
<p><b>Conditions Requiring Multiple Treatments:</b> Restorative surgery after an accident or other injury; or, a condition that would likely result in a period of incapacity of more than three consecutive, full calendar days if the patient did not receive the treatment.</p>

**PAPERWORK REDUCTION ACT NOTICE AND PUBLIC BURDEN STATEMENT**

If submitted, it is mandatory for employers to retain a copy of this disclosure in their records for three years. 29 U.S.C. § 2616; 29 C.F.R. § 825.500. Persons are not required to respond to this collection of information unless it displays a currently valid OMB control number. The Department of Labor estimates that it will take an average of 15 minutes for respondents to complete this collection of information, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. If you have any comments regarding this burden estimate or any other aspect of this collection information, including suggestions for reducing this burden, send them to the Administrator, Wage and Hour Division, U.S. Department of Labor, Room S-3502, 200 Constitution Avenue, N.W., Washington, D.C. 20210.

**DO NOT SEND COMPLETED FORM TO THE DEPARTMENT OF LABOR. RETURN TO THE PATIENT.**

**Certification of Health Care Provider for  
Family Member’s Serious Health Condition  
under the Family and Medical Leave Act**

**U.S. Department of Labor  
Wage Hour Division**



**DO NOT SEND COMPLETED FORM TO THE DEPARTMENT OF LABOR.  
RETURN TO THE PATIENT.**

OMB Control Number: 1235-0003  
Expires: 6/30/2023

The Family and Medical Leave Act (FMLA) provides that an employer may require an employee seeking FMLA leave to care for a family member with a serious health condition to submit a medical certification issued by the family member’s health care provider. 29 U.S.C. §§ 2613, 2614(c)(3); 29 C.F.R. § 825.305. The employer must give the employee **at least 15 calendar days** to provide the certification. If the employee fails to provide complete and sufficient medical certification, his or her FMLA leave request may be denied. 29 C.F.R. § 825.313. Information about the FMLA may be found [on the WHD website at www.dol.gov/agencies/whd/fmla](http://www.dol.gov/agencies/whd/fmla).

**SECTION I - EMPLOYER**

Either the employee or the employer may complete Section I. While use of this form is optional, this form asks the health care provider for the information necessary for a complete and sufficient medical certification, which is set out at 29 C.F.R. § 825.306. **You may not ask the employee to provide more information than allowed under the FMLA regulations, 29 C.F.R. §§ 825.306-825.308.** Additionally, you **may not** request a certification for FMLA leave to bond with a healthy newborn child or a child placed for adoption or foster care.

Employers must generally maintain records and documents relating to medical information, medical certifications, recertifications, or medical histories of employees or employees’ family members created for FMLA purposes as confidential medical records in separate files/records from the usual personnel files and in accordance with 29 C.F.R. § 1630.14(c)(1), if the Americans with Disabilities Act applies, and in accordance with 29 C.F.R. § 1635.9, if the Genetic Information Nondiscrimination Act applies.

(1) Employee name: \_\_\_\_\_  
*First Middle Last*

(2) Employer name: \_\_\_\_\_ Date: \_\_\_\_\_ (mm/dd/yyyy)  
*(List date certification requested)*

(3) The medical certification must be returned by \_\_\_\_\_ (mm/dd/yyyy)  
*(Must allow at least 15 calendar days from the date requested, unless it is not feasible despite the employee’s diligent, good faith efforts.)*

**SECTION II - EMPLOYEE**

Please complete and sign Section II before providing this form to your family member or your family member’s health care provider. The FMLA allows an employer to require that you submit a timely, complete, and sufficient medical certification to support a request for FMLA leave due to the serious health condition of your family member. If requested by your employer, your response is required to obtain or retain the benefit of the FMLA protections. 29 U.S.C. §§ 2613, 2614(c)(3). **You are responsible for making sure the medical certification is provided to your employer within the time frame requested, which must be at least 15 calendar days.** 29 C.F.R. §§ 825.305-825.306. Failure to provide a complete and sufficient medical certification may result in a denial of your FMLA leave request. 29 C.F.R. § 825.313.

(1) Name of the family member for whom you will provide care: \_\_\_\_\_

- (2) Select the relationship of the family member to you. The family member is your:
- Spouse
  - Parent
  - Child, under age 18
  - Child, age 18 or older and incapable of self-care because of a mental or physical disability

Spouse means a husband or wife as defined or recognized in the state where the individual was married, including in a common law marriage or same-sex marriage. The terms “child” and “parent” include *in loco parentis* relationships in which a person assumes the obligations of a parent to a child. An employee may take FMLA leave to care for an individual who assumed the obligations of a parent to the employee when the employee was a child. An employee may also take FMLA leave to care for a child for whom the employee has assumed the obligations of a parent. No legal or biological relationship is necessary.

Employee Name: \_\_\_\_\_

(3) Briefly describe the care you will provide to your family member: *(Check all that apply)*

- Assistance with basic medical, hygienic, nutritional, or safety needs  Transportation  
 Physical Care  Psychological Comfort  Other: \_\_\_\_\_

(4) Give your **best estimate** of the amount of leave needed to provide the care described: \_\_\_\_\_

(5) If a **reduced work schedule** is necessary to provide the care described, give your **best estimate** of the reduced schedule you are able to work. From \_\_\_\_\_ *(mm/dd/yyyy)* to \_\_\_\_\_ *(mm/dd/yyyy)*, I am able to work \_\_\_\_\_ *(hours per day)* \_\_\_\_\_ *(days per week)*.

Employee

Signature \_\_\_\_\_ Date \_\_\_\_\_ *(mm/dd/yyyy)*

### SECTION III - HEALTH CARE PROVIDER

Please provide your contact information, complete all relevant parts of this Section, and sign the form below. A family member of your patient has requested leave under the FMLA to care for your patient. The FMLA allows an employer to require that the employee submit a timely, complete, and sufficient medical certification to support a request for FMLA leave to care for a family member with a serious health condition. For FMLA purposes, a "serious health condition" means an illness, injury, impairment, or physical or mental condition that *involves inpatient care or continuing treatment by a health care provider*. For more information about the definitions of a serious health condition under the FMLA, see the chart at the end of the form.

You also may, but are **not required** to, provide other appropriate medical facts including symptoms, diagnosis, or any regimen of continuing treatment such as the use of specialized equipment. Please note that some state or local laws may not allow disclosure of private medical information about the patient's serious health condition, such as providing the diagnosis and/or course of treatment.

Health Care Provider's name: *(Print)* \_\_\_\_\_

Health Care Provider's business address: \_\_\_\_\_

Type of practice / Medical specialty: \_\_\_\_\_

Telephone: (\_\_\_\_) \_\_\_\_\_ Fax: (\_\_\_\_) \_\_\_\_\_ E-mail: \_\_\_\_\_

#### **PART A: Medical Information**

Limit your response to the medical condition for which the employee is seeking FMLA leave. Your answers should be your **best estimate** based upon your medical knowledge, experience, and examination of the patient. **After completing Part A, complete Part B to provide information about the amount of leave needed.** Note: For FMLA purposes, "incapacity" means the inability to work, attend school, or perform regular daily activities due to the condition, treatment of the condition, or recovery from the condition. Do not provide information about genetic tests, as defined in 29 C.F.R. § 1635.3(f), genetic services, as defined in 29 C.F.R. § 1635.3(e), or the manifestation of disease or disorder in the employee's family members, 29 C.F.R. § 1635.3(b).

(1) Patient's Name: \_\_\_\_\_

(2) State the approximate date the condition started or will start: \_\_\_\_\_ *(mm/dd/yyyy)*

(3) Provide your **best estimate** of how long the condition lasted or will last: \_\_\_\_\_

(4) For FMLA to apply, care of the patient must be medically necessary. Briefly describe the type of care needed by the patient *(e.g., assistance with basic medical, hygienic, nutritional, safety, transportation needs, physical care, or psychological comfort)*.  
\_\_\_\_\_  
\_\_\_\_\_

Employee Name: \_\_\_\_\_

(5) Check the box(es) for the questions below, as applicable. For all box(es) checked, the amount of leave needed must be provided in Part B.

**Inpatient Care:** The patient ( has been /  is expected to be) admitted for an overnight stay in a hospital, hospice, or residential medical care facility on the following date(s): \_\_\_\_\_

**Incapacity plus Treatment:** (e.g. outpatient surgery, strep throat)

Due to the condition, the patient ( has been /  is expected to be) incapacitated for *more than three* consecutive, full calendar days from \_\_\_\_\_ (mm/dd/yyyy) to \_\_\_\_\_ (mm/dd/yyyy).

The patient ( was /  will be) seen on the following date(s): \_\_\_\_\_

The condition ( has /  has not) also resulted in a course of continuing treatment under the supervision of a health care provider (e.g. prescription medication (other than over-the-counter) or therapy requiring special equipment)

**Pregnancy:** The condition is pregnancy. List the expected delivery date: \_\_\_\_\_ (mm/dd/yyyy).

**Chronic Conditions:** (e.g. asthma, migraine headaches) Due to the condition, it is medically necessary for the patient to have treatment visits at least twice per year.

**Permanent or Long Term Conditions:** (e.g. Alzheimer's, terminal stages of cancer) Due to the condition, incapacity is permanent or long term and requires the continuing supervision of a health care provider (even if active treatment is not being provided).

**Conditions requiring Multiple Treatments:** (e.g. chemotherapy treatments, restorative surgery) Due to the condition, it is medically necessary for the patient to receive multiple treatments.

**None of the above:** If none of the above condition(s) were checked, (i.e., inpatient care, pregnancy) no additional information is needed. Go to page 4 to sign and date the form.

(6) If needed, briefly describe other appropriate medical facts related to the condition(s) for which the employee seeks FMLA leave. (e.g., use of nebulizer, dialysis) \_\_\_\_\_

### **PART B: Amount of Leave Needed**

For the medical condition(s) checked in Part A, complete all that apply. Several questions seek a response as to the frequency or duration of a condition, treatment, etc. Your answer should be your **best estimate** based upon your medical knowledge, experience, and examination of the patient. Be as specific as you can; terms such as "lifetime," "unknown," or "indeterminate" may not be sufficient to determine if the benefits and protections of the FMLA apply.

(7) Due to the condition, the patient ( had /  will have) **planned medical treatment(s)** (scheduled medical visits) (e.g. psychotherapy, prenatal appointments) on the following date(s): \_\_\_\_\_

(8) Due to the condition, the patient ( was /  will be) **referred to other health care provider(s)** for evaluation or treatment(s).

State the nature of such treatments: (e.g. cardiologist, physical therapy) \_\_\_\_\_

Provide your **best estimate** of the beginning date \_\_\_\_\_ (mm/dd/yyyy) and end date \_\_\_\_\_ (mm/dd/yyyy) for the treatment(s).

Provide your **best estimate** of the duration of the treatment(s), including any period(s) of recovery \_\_\_\_\_ (e.g. 3 days/week)

Employee Name: \_\_\_\_\_

- (9) Due to the condition, the patient ( was /  will be) **incapacitated for a continuous period of time**, including any time for treatment(s) and/or recovery.

Provide your **best estimate** of the beginning date: \_\_\_\_\_ (mm/dd/yyyy) and end date \_\_\_\_\_ (mm/dd/yyyy) for the period of incapacity.

- (10) Due to the condition it, ( was /  is /  will be) medically necessary for the employee to be absent from work to provide care for the patient on an **intermittent basis** (periodically), including for any episodes of incapacity i.e., episodic flare-ups. Provide your **best estimate** of how often (frequency) and how long (duration) the episodes of incapacity will likely last.

Over the next 6 months, episodes of incapacity are estimated to occur \_\_\_\_\_ times per ( day /  week /  month) and are likely to last approximately \_\_\_\_\_ (  hours /  days) per episode.

Signature of Health Care Provider \_\_\_\_\_ Date \_\_\_\_\_ (mm/dd/yyyy)

Definitions of a Serious Health Condition (See 29 C.F.R. §§ 825.113-.115)
<b>Inpatient Care</b>
<ul style="list-style-type: none"><li>• An overnight stay in a hospital, hospice, or residential medical care facility.</li><li>• Inpatient care includes any period of incapacity or any subsequent treatment in connection with the overnight stay.</li></ul>
<b>Continuing Treatment by a Health Care Provider (any one or more of the following)</b>
<p><b>Incapacity Plus Treatment:</b> A period of incapacity of more than three consecutive, full calendar days, and any subsequent treatment or period of incapacity relating to the same condition, that also involves either:</p> <ul style="list-style-type: none"><li>○ Two or more in-person visits to a health care provider for treatment within 30 days of the first day of incapacity unless extenuating circumstances exist. The first visit must be within seven days of the first day of incapacity; or,</li><li>○ At least one in-person visit to a health care provider for treatment within seven days of the first day of incapacity, which results in a regimen of continuing treatment under the supervision of the health care provider. For example, the health provider might prescribe a course of prescription medication or therapy requiring special equipment.</li></ul>
<p><b>Pregnancy:</b> Any period of incapacity due to pregnancy or for prenatal care.</p>
<p><b>Chronic Conditions:</b> Any period of incapacity due to or treatment for a chronic serious health condition, such as diabetes, asthma, migraine headaches. A chronic serious health condition is one which requires visits to a health care provider (or nurse supervised by the provider) at least twice a year and recurs over an extended period of time. A chronic condition may cause episodic rather than a continuing period of incapacity.</p>
<p><b>Permanent or Long-term Conditions:</b> A period of incapacity which is permanent or long-term due to a condition for which treatment may not be effective, but which requires the continuing supervision of a health care provider, such as Alzheimer’s disease or the terminal stages of cancer.</p>
<p><b>Conditions Requiring Multiple Treatments:</b> Restorative surgery after an accident or other injury; or, a condition that would likely result in a period of incapacity of more than three consecutive, full calendar days if the patient did not receive the treatment.</p>

**PAPERWORK REDUCTION ACT NOTICE AND PUBLIC BURDEN STATEMENT**

If submitted, it is mandatory for employers to retain a copy of this disclosure in their records for three years. 29 U.S.C. § 2616; 29 C.F.R. § 825.500. Persons are not required to respond to this collection of information unless it displays a currently valid OMB control number. The Department of Labor estimates that it will take an average of 15 minutes for respondents to complete this collection of information, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. If you have any comments regarding this burden estimate or any other aspect of this collection information, including suggestions for reducing this burden, send them to the Administrator, Wage and Hour Division, U.S. Department of Labor, Room S-3502, 200 Constitution Avenue, N.W., Washington, D.C. 20210.

**DO NOT SEND COMPLETED FORM TO THE DEPARTMENT OF LABOR. RETURN TO THE PATIENT.**

**Certification for Military Family Leave for  
Qualifying Exigency  
under the Family and Medical Leave Act**

**U.S. Department of Labor  
Wage and Hour Division**



**DO NOT SEND FORM TO THE DEPARTMENT OF LABOR.  
RETURN THE COMPLETED FORM TO THE EMPLOYER.**

OMB Control Number: 1235-0003  
Expires: 6/30/2023

The Family and Medical Leave Act (FMLA) provides that eligible employees may take FMLA leave for a qualifying exigency while the employee's spouse, child, or parent (the military member) is on covered active duty or has been notified of an impending call or order to covered active duty. The FMLA allows an employer to require an employee seeking FMLA leave due to a qualifying exigency to submit a certification. 29 U.S.C. §§ 2613, 2614(c)(3). The employer must give the employee **at least 15 calendar days** to provide the certification. 29 C.F.R. § 825.305(b). If the employee fails to provide complete and sufficient certification, the employee's FMLA leave request may be denied. 29 C.F.R. § 825.313. Information about the FMLA may be found [on the WHD website at http://www.dol.gov/agencies/whd/fmla](http://www.dol.gov/agencies/whd/fmla).

**SECTION I - EMPLOYER**

Either the employee or the employer may complete Section I. While use of this form is optional, it asks the employee for the information necessary for a complete and sufficient qualifying exigency certification, which is set out at 29 C.F.R. § 825.309. **You may not ask the employee to provide more information than allowed under the FMLA regulations, 29 C.F.R. § 825.309.**

- (1) Employee name: \_\_\_\_\_  
*First Middle Last*
- (2) Employer name: \_\_\_\_\_ Date: \_\_\_\_\_ (mm/dd/yyyy)  
*(List date certification requested)*
- (3) This certification must be returned by \_\_\_\_\_ (mm/dd/yyyy).  
*(Must allow at least 15 calendar days from the date requested, unless it is not feasible despite the employee's diligent, good faith efforts.)*

**SECTION II - EMPLOYEE**

Please complete all Parts of Section II and sign the form before returning it to your employer. The FMLA allows an employer to require that you submit a timely, complete, and sufficient certification to support a request for FMLA leave due to a qualifying exigency. If requested by your employer, your response is required to obtain the benefits and protections of the FMLA. 29 C.F.R. § 825.309. Failure to provide a complete and sufficient certification may result in a denial of your FMLA leave request. A complete and sufficient certification to support a request for FMLA leave due to a qualifying exigency includes written documentation confirming a military member's covered active duty or call to covered active duty status. **You are responsible for making sure the certification is provided to your employer within the time frame requested, which must be at least 15 calendar days.** 29 C.F.R. § 825.313.

- (1) Provide the name of the military member on covered active duty or call to covered active duty status:  
\_\_\_\_\_  
*First Middle Last*
- (2) Select your relationship of the military member. The military member is your:  
 Spouse     Parent     Child, of any age

Spouse means a husband or wife as defined or recognized in the state where the individual was married, including a common law marriage or same-sex marriage. The terms "child" and "parent" include *in loco parentis* relationships in which a person assumes the obligations of a parent to a child. An employee may take FMLA leave for a qualifying exigency related a military member who assumed the obligations of a parent to the employee when the employee was a child. An employee may also take FMLA leave for a qualifying exigency related a military member for whom the employee has assumed the obligations of a parent. No legal or biological relationship is necessary.

Employee Name: \_\_\_\_\_

**PART A: COVERED ACTIVE DUTY STATUS**

Covered active duty or call to covered active duty in the case of a member of the Regular Armed Forces means duty during the deployment of the member with the Armed Forces to a foreign country. Covered active duty or call to covered active duty in the case of a member of the Reserve components means duty during the deployment of the member with the Armed Forces to a foreign country under a Federal call or order to active duty in support of a contingency operation pursuant to: Section 688 of Title 10 of the United States Code; Section 12301(a) of Title 10 of the United States Code; Section 12302 of Title 10 of the United States Code; Section 12304 of Title 10 of the United States Code; Section 12305 of Title 10 of the United States Code; Section 12406 of Title 10 of the United States Code; chapter 15 of Title 10 of the United States Code; or, any other provision of law during a war or during a national emergency declared by the President or Congress so long as it is in support of a contingency operation. 10 U.S.C. § 101(a)(13)(B).

An employer may require the employee to provide a copy of the military member's active duty orders or other documentation issued by the military which indicates that the military member is on covered active duty or call to covered active duty status, and the dates of the military member's covered active duty service. **This information need only be provided to the employer once, unless additional leave is needed for a different military member or different deployment.**

(3) Provide the dates of the military member's covered active duty service: \_\_\_\_\_

(4) Please check one of the following and attach the indicated written document to support that the military member is on covered active duty or call to covered active duty status:

- A copy of the military member's covered active duty orders
- Other documentation from the military indicating that the military member is on covered active duty or has been notified of an impending call to covered active duty, such as official military correspondence from the military member's chain of command
- I have previously provided my employer with sufficient written documentation confirming the military member's covered active duty or call to covered active duty status

**PART B: APPROPRIATE FACTS**

Under the FMLA, leave can be taken for a number of qualifying exigencies. 29 C.F.R. § 825.126(b). Complete and sufficient certification to support a request for FMLA leave due to a qualifying exigency includes available written documentation which supports the need for leave such as a copy of a meeting announcement for informational briefings sponsored by the military, a document confirming the military member's Rest and Recuperation leave, or other documentation issued by the military which indicates that the military member has been granted Rest and Recuperation leave, or a document confirming an appointment with a third party (e.g., a counselor or school official, or staff at a care facility, a copy of a bill for services for the handling of legal or financial affairs). Please provide appropriate facts related to the particular qualifying exigency to support the FMLA leave request, including information on the type of qualifying exigency and any available written documentation of the exigency event.

(5) Select the appropriate **Qualifying Exigency Category** and, if needed, provide additional information related to the event:

- Short notice deployment (*i.e.*, deployment within seven or fewer days of notice)
- Military events and related activities (*e.g.*, official ceremonies or events, or family support and assistance programs):  
\_\_\_\_\_
- Childcare related activities for the child of the military member (*e.g.*, arranging for alternative childcare):  
\_\_\_\_\_

Employee Name: \_\_\_\_\_

- Care for the military member's parent (*e.g., admitting or transferring the parent to a new care facility*):  
\_\_\_\_\_
  - Financial and legal arrangements related to the deployment (*e.g., obtaining military identification cards*)
  - Counseling related to the deployment (*i.e., counseling provided by someone other than a health care provider*)
  - Military member's short-term, temporary Rest and Recuperation leave (R&R) (leave for this reason is limited to 15 calendar days for each instance of R&R)
  - Post deployment activities (*e.g., arrival ceremonies, or reintegration briefings and events*): \_\_\_\_\_
  - Any other event that the employee and employer agree is a qualifying exigency: \_\_\_\_\_
- (6) **Available written documentation** supporting this request for leave is ( attached /  not attached /  not available).

**PART C: AMOUNT OF LEAVE NEEDED**

**Provide information concerning the amount of leave that will be needed.** Several questions in this section seek a response as to the frequency or duration of the qualifying exigency leave needed. Be as specific as you can; terms such as "unknown" or "indeterminate" may not be sufficient to determine FMLA coverage.

(7) List the approximate date exigency started or will start: \_\_\_\_\_ (mm/dd/yyyy)

(8) Provide your best estimate of how long the exigency lasted or will last:

From \_\_\_\_\_ (mm/dd/yyyy) to \_\_\_\_\_ (mm/dd/yyyy)

(9) Due to a qualifying exigency, I need to work a **reduced schedule**. Provide your **best estimate** of the reduced schedule you are able to work:

From \_\_\_\_\_ (mm/dd/yyyy) to \_\_\_\_\_ (mm/dd/yyyy)

I am able to work \_\_\_\_\_  
(*e.g., 5 hours/day, up to 25 hours a week*)

(10) Due to a qualifying exigency, I will need to be absent from work for a **continuous period of time**. Provide your **best estimate** of the beginning and ending dates for the period of absence:

From \_\_\_\_\_ (mm/dd/yyyy) to \_\_\_\_\_ (mm/dd/yyyy)

**Employee Name:** \_\_\_\_\_

(11) Due to a qualifying exigency, I will need to be absent from work on an **intermittent basis** (periodically).

Provide your **best estimate** of the frequency (how often) and duration (how long) of each appointment, meeting, or leave event, including any travel time.

Over the next 6 months, absences on an **intermittent basis** are estimated to occur: \_\_\_\_\_ times per  
(  day /  week /  month ) and are likely to last approximately \_\_\_\_\_ (  hours /  days ) per episode.

(12) My leave is due to a qualifying exigency that involves **Rest and Recuperation leave** (R & R) of the military member (leave for this reason is limited to 15 calendar days for each instance of R & R leave).

List the dates of the military member's R & R leave:

From \_\_\_\_\_ (mm/dd/yyyy) to \_\_\_\_\_ (mm/dd/yyyy)

**PART D: THIRD PARTY INFORMATION**

If applicable, please provide information below that may be used by your employer to verify meetings or appointments with a third party related to the qualifying exigency. Examples of meetings with third parties include: arranging for childcare or parental care, to attend non-medical counseling, to attend meetings with school, childcare or parental care providers, to make financial or legal arrangements, to act as the military member's representative before a federal, state, or local agency for purposes of obtaining, arranging or appealing military service benefits, or to attend any event sponsored by the military or military service organizations. This information may be used by your employer to verify that the information contained on this form is accurate.

Individual (e.g., name and title) or Entity / Organization: \_\_\_\_\_

Address: \_\_\_\_\_

Telephone: (\_\_\_\_) \_\_\_\_\_ Fax: (\_\_\_\_) \_\_\_\_\_ E-mail: \_\_\_\_\_

Describe purpose of meeting: \_\_\_\_\_

**Employee Signature** \_\_\_\_\_ **Date** \_\_\_\_\_ (mm/dd/yyyy)

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**PAPERWORK REDUCTION ACT NOTICE AND PUBLIC BURDEN STATEMENT**

If submitted, it is mandatory for employers to retain a copy of this disclosure in their records for three years. 29 U.S.C. § 2616; 29 C.F.R. § 825.500. Persons are not required to respond to this collection of information unless it displays a currently valid OMB control number. The Department of Labor estimates that it will take an average of 15 minutes for respondents to complete this collection of information, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. If you have any comments regarding this burden estimate or any other aspect of this collection information, including suggestions for reducing this burden, send them to the Administrator, Wage and Hour Division, U.S. Department of Labor, Room S-3502, 200 Constitution Avenue, N.W., Washington, D.C. 20210.

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**DO NOT SEND THE COMPLETED FORM TO THE DEPARTMENT OF LABOR.  
RETURN FORM TO THE EMPLOYER.**

**Certification for Serious Injury or Illness of a  
Current Servicemember for Military Caregiver Leave  
under the Family and Medical Leave Act**

**U.S. Department of Labor  
Wage Hour Division**



**DO NOT SEND COMPLETED FORM TO THE DEPARTMENT OF LABOR.  
RETURN TO THE PATIENT.**

OMB Control Number: 1235-0003  
Expires: 6/30/2023

The Family and Medical Leave Act (FMLA) provides that eligible employees may take FMLA leave to care for a covered servicemember with a serious illness or injury. The FMLA allows an employer to require an employee seeking FMLA leave for this purpose to submit a medical certification. 29 U.S.C. §§ 2613, 2614(c)(3). The employer must give the employee **at least 15 calendar days** to provide the certification. If the employee fails to provide complete and sufficient certification, his or her FMLA leave request may be denied. 29 C.F.R. § 825.313. Information about the FMLA may be found [on the WHD website at www.dol.gov/agencies/whd/fmla](http://www.dol.gov/agencies/whd/fmla).

### SECTION I - EMPLOYER

Either the employee or the employer may complete Section I. While use of this form is optional, it asks the health care provider for the information necessary for a complete and sufficient medical certification. **You may not ask the employee to provide more information than allowed under the FMLA regulations, 29 C.F.R. § 825.310. Recertifications are not allowed for FMLA leave to care for a covered servicemember. Where medical certification is requested by an employer, an employee may not be held liable for administrative delays in the issuance of military documents, despite the employee's diligent, good-faith efforts to obtain such documents.** An employer requiring an employee to submit a certification for leave to care for a covered servicemember **must** accept as sufficient certification invitational travel orders (ITOs) or invitational travel authorizations (ITAs) issued to any family member to join an injured or ill servicemember at the servicemember's bedside. An ITO or ITA is sufficient certification for the duration of time specified in the ITO or ITA.

Employers must generally maintain records and documents relating to medical information, medical certifications, recertifications, or medical histories of employees or employees' family members created for FMLA purposes as confidential medical records in separate files/records from the usual personnel files and in accordance with 29 C.F.R. § 1630.14(c)(1), if the Americans with Disabilities Act applies, and in accordance with 29 C.F.R. § 1635.9, if the Genetic Information Nondiscrimination Act applies.

- (1) Employee name: \_\_\_\_\_  
*First Middle Last*
- (2) Employer name: \_\_\_\_\_ Date: \_\_\_\_\_ (mm/dd/yyyy)  
*(List date certification requested)*
- (3) This certification must be returned by: \_\_\_\_\_ (mm/dd/yyyy)  
*(Must allow at least 15 calendar days from the date requested, unless it is not feasible despite the employee's diligent, good faith efforts.)*

### SECTION II - EMPLOYEE and/or CURRENT SERVICEMEMBER

Please complete all Parts of Section II before having the servicemember's health care provider complete Section III. The FMLA allows an employer to require that an employee submit a timely, complete, and sufficient certification to support a request for FMLA leave due to a serious injury or illness of a covered servicemember. If requested by your employer, your response is required to obtain or retain the benefit of FMLA-protected leave.

#### **PART A: EMPLOYEE INFORMATION**

- (1) Name of the current servicemember for whom employee is requesting leave: \_\_\_\_\_

**Employee Name:** \_\_\_\_\_

(2) Select your relationship to the current servicemember. You are the current servicemember's:

- Spouse                       Parent                       Child                       Next of Kin

Spouse means a husband or wife as defined or recognized in the state where the individual was married, including a common law marriage or same-sex marriage. The terms "child" and "parent" include *in loco parentis* relationships in which a person assumes the obligations of a parent to a child. An employee may take FMLA leave to care for a covered servicemember who assumed the obligations of a parent to the employee when the employee was a child. An employee may also take FMLA leave to care for a covered servicemember for whom the employee has assumed the obligations of a parent. No biological or legal relationship is necessary. "Next of kin" is the servicemember's nearest blood relative, other than the spouse, parent, son, or daughter, in the following order of priority: (1) a blood relative as designated in writing by the servicemember for purposes of FMLA leave, (2) blood relatives granted legal custody of the servicemember, (3) brothers and sisters, (4) grandparents, (5) aunts and uncles, and (6) first cousins.

**PART B: SERVICEMEMBER INFORMATION AND CARE TO BE PROVIDED TO THE SERVICEMEMBER**

(3) The servicemember ( is /  is not) a current member of the Regular Armed Forces, the National Guard or Reserves. If yes, provide the servicemember's military branch, rank and unit currently assigned to: \_\_\_\_\_  
\_\_\_\_\_

(4) The servicemember ( is /  is not) assigned to a military medical treatment facility as an outpatient or to a unit established for the purpose of providing command and control of members of the Armed Forces receiving medical care as outpatients, such as a medical hold or warrior transition unit. If yes, provide the name of the medical treatment facility or unit: \_\_\_\_\_  
\_\_\_\_\_

(5) The servicemember ( is /  is not) on the Temporary Disability Retired List (TDRL).

(6) Briefly describe the care you will provide to the servicemember: *(Check all that apply)*  
 Assistance with basic medical, hygienic, nutritional, or safety needs  
 Psychological Comfort                       Physical Care  
 Transportation                                       Other: \_\_\_\_\_

(7) Give your **best estimate** of the amount of leave needed to provide the care described: \_\_\_\_\_  
\_\_\_\_\_

(8) If a reduced work schedule is necessary to provide the care described, give your **best estimate** of the reduced work schedule you are able to work. From \_\_\_\_\_ (mm/dd/yyyy) to \_\_\_\_\_ (mm/dd/yyyy), I am able to work: \_\_\_\_\_ (hours per day) \_\_\_\_\_ (days per week).

**SECTION III - HEALTH CARE PROVIDER**

Please provide your contact information, complete all Parts of this Section fully and completely, and sign the form below. The employee listed at Section I has requested leave under the FMLA to care for a family member who is a current member of the Regular Armed Forces, the National Guard, or the Reserves who is undergoing medical treatment, recuperation, or therapy, is otherwise in outpatient status, or is otherwise on the temporary disability retired list for a serious injury or illness. Note: For purposes of FMLA leave, a serious injury or illness is one that was incurred in the line of duty on active duty in the Armed Forces or that existed before the beginning of the member's active duty and was aggravated by service in the line of duty on active duty in the Armed Forces that may render the servicemember medically unfit to perform the duties of the servicemember's office, grade, rank, or rating. "Need for care" includes both physical and psychological care. It includes situations where, for example, due to his or her serious injury or illness, the servicemember is not able to care for his or her own basic medical, hygienic, or nutritional needs or safety, or needs transportation to the doctor. It also includes providing psychological comfort and reassurance which would be beneficial to the servicemember who is receiving inpatient or home

**Employee Name:** \_\_\_\_\_

care. A complete and sufficient certification to support a request for FMLA leave due to a current servicemember's serious injury or illness includes written documentation confirming that the servicemember's injury or illness was incurred in the line of duty on active duty or if not, that the current servicemember's injury or illness existed before the beginning of the servicemember's active duty and was aggravated by service in the line of duty on active duty in the Armed Forces, and that the current servicemember is undergoing treatment for such injury or illness by a health care provider listed above.

**PART A: HEALTH CARE PROVIDER INFORMATION**

Health Care Provider's Name: *(Print)* \_\_\_\_\_

Health Care Provider's business address: \_\_\_\_\_

Type of practice/Medical specialty: \_\_\_\_\_

Telephone: (\_\_\_\_) \_\_\_\_\_ Fax: (\_\_\_\_) \_\_\_\_\_ E-mail: \_\_\_\_\_

Please select the type of FMLA health care provider you are:

- DOD health care provider
- VA health care provider
- DOD TRICARE network authorized private health care provider
- DOD non-network TRICARE authorized private health care provider
- Health care provider as defined in 29 C.F.R. § 825.125

**PART B: MEDICAL INFORMATION**

Please provide appropriate medical information of the patient as requested below. Limit your responses to the servicemember's condition for which the employee is seeking leave. If you are unable to make some of the military-related determinations contained below, you are permitted to rely upon determinations from an authorized DOD representative, such as a DOD recovery care coordinator. Do not provide information about genetic tests, as defined in 29 C.F.R. § 1635.3(f), or genetic services, as defined in 29 C.F.R. § 1635.3(e).

(1) Patient's Name: \_\_\_\_\_

(2) List the approximate date condition started or will start: \_\_\_\_\_ *(mm/dd/yyyy)*

(3) Provide your **best estimate** of how long the condition will last: \_\_\_\_\_

(4) The servicemember's injury or illness: *(Select as appropriate)*

- Was incurred in the line of duty on active duty.
- Existed before the beginning of the servicemember's active duty and was aggravated by service in the line of duty on active duty.
- None of the above.

(5) The servicemember ( is /  is not) undergoing medical treatment, recuperation, or therapy for this condition.

If yes, briefly describe the medical treatment, recuperation or therapy: \_\_\_\_\_

Employee Name: \_\_\_\_\_

- (6) The current servicemember's medical condition is classified as: *(Select as appropriate)*
- (VSI) Very Seriously Ill/Injured** Illness/Injury is of such a severity that life is imminently endangered. Family members are requested at bedside immediately. *Please note this is an internal DOD casualty assistance designation used by DOD healthcare providers.*
  - (SI) Seriously Ill/Injured** Illness/injury is of such severity that there is cause for immediate concern, but there is no imminent danger to life. Family members are requested at bedside. *Please note this is an internal DOD casualty assistance designation used by DOD healthcare providers.*
  - OTHER Ill/Injured** A serious injury or illness that may render the servicemember medically unfit to perform the duties of the member's office, grade, rank, or rating.
  - NONE OF THE ABOVE.** *Note to Employee: If this box is checked, you may still be eligible to take leave to care for a covered family member with a "serious health condition" under 29 C.F.R. § 825.113 of the FMLA. If such leave is requested, you may be required to complete DOL FORM WH-380-F or an employer-provided form seeking the same information.*

**PART C: AMOUNT OF LEAVE NEEDED**

For the medical condition checked in Part B, complete all that apply. Some questions seek a response as to the frequency or duration of a condition, treatment, etc. Your answer should be your **best estimate** based upon your medical knowledge, experience, and examination of the patient. Be as specific as you can; terms such as "lifetime," "unknown," or "indeterminate" may not be sufficient to determine FMLA coverage.

- (7) Due to the condition, the servicemember will need care for a **continuous period of time**, including any time for treatment and recovery. Provide your **best estimate** of the beginning date \_\_\_\_\_ (mm/dd/yyyy) and end date \_\_\_\_\_ (mm/dd/yyyy) for this period of time.
- (8) Due to the condition, it is medically necessary for the servicemember to attend **planned medical treatment** appointments (scheduled medical visits). Provide your **best estimate** of the duration of the treatment(s), including any period(s) of recovery \_\_\_\_\_ (e.g. 3 days/week)
- (9) Due to the condition, it is medically necessary for the servicemember to receive care on an **intermittent basis** (periodically), such as the care needed because of episodic flare-ups of the condition or assisting with the servicemember's recovery. Provide your **best estimate** of how often (frequency) and how long (the duration) the intermittent episodes will likely last.

Over the next 6 months, intermittent care is estimated to occur \_\_\_\_\_ times per  
( day /  week /  month) and are likely to last approximately \_\_\_\_\_ (  hours /  days) per episode.

Signature of  
Health Care Provider \_\_\_\_\_ Date \_\_\_\_\_ (mm/dd/yyyy)

**PAPERWORK REDUCTION ACT NOTICE AND PUBLIC BURDEN STATEMENT**

If submitted, it is mandatory for employers to retain a copy of this disclosure in their records for three years, in accordance with 29 U.S.C. § 2616; 29 C.F.R. § 825.500. Persons are not required to respond to this collection of information unless it displays a currently valid OMB control number. The Department of Labor estimates that it will take an average of 15 minutes for respondents to complete this collection of information, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. If you have any comments regarding this burden estimate or any other aspect of this collection information, including suggestions for reducing this burden, send them to the Administrator, Wage and Hour Division, U.S. Department of Labor, Room S-3502, 200 Constitution Avenue, N.W., Washington, D.C. 20210.

**DO NOT SEND THE COMPLETED FORM TO THE DEPARTMENT OF LABOR. RETURN IT TO THE PATIENT.**

## **Internal Controls**

The District will develop and maintain internal control procedures as required by law and in accordance with sound fiscal monitoring practices that will ensure appropriate oversight of state and federal funds. The following internal control procedures will be utilized for all federal grants:

**Management requirements:** The District will manage equipment (including replacement equipment), whether acquired in whole or in part under a federal award, until the District disposes of such equipment.

**Procurement:** The District will use its own documented procurement procedures which reflect applicable State, local, and tribal laws and regulations, provided that the procurements conform to applicable Federal law and the requirement standards imposed by law.

**Record Retention:** Financial records, supporting documents, statistical records, and all other related records pertinent to a federal award will be retained for a period of three years from the date of submission of the final expenditure report or, for Federal awards that are renewed quarterly or annually, from the date of the submission of the quarterly or annual financial report, respectively, as reported to the federal awarding agency or pass-through entity in the case of a sub-recipient.

For all other records, the District will retain such records for the length of time as required by law.

Legal Reference: 2 C.F.R. § 200.333.

**Suspension and Debarment:** The District will not contract with any entity or individual who has been debarred, suspended, or otherwise excluded from or ineligible for participation in federal assistance programs or activities. Before entering into a contract regarding a federal award, the District will verify that a vendor has not been debarred, suspended or otherwise excluded, and the District will maintain a copy of said verification.

Legal Reference: 2 C.F.R. § 200.213.

**Financial Management:** The District will maintain financial management systems to account for the federal funds, including records documenting compliance with federal statutes, regulations, and the terms and conditions of the federal award. These records will be sufficient to permit the District to prepare reports required by general and program-specific terms and conditions; and the tracing of funds to a level of expenditures adequate to establish that such funds have been used according to the Federal statutes, regulations, and the terms and conditions of the Federal award.

**Program Income:** The District will consult with the federal awarding agency and refer to the applicable law and federal program terms and conditions to determine how to account for, deduct and otherwise handle income from federal programs.

Legal Reference: 2 C.F.R. § 200.307.

Cost Sharing or Matching: For all federal awards, any shared costs or matching funds and all contributions, including cash and third party in-kind contributions, must be accepted as part of the District's cost sharing or matching, when such contributions meet all of the following criteria:

- 1) Are verifiable from the District's records;
- 2) Are not included as contributions for any other Federal award;
- 3) Are necessary and reasonable for accomplishment of project or program objectives;
- 4) Are allowable under the applicable Cost Principles requirements;
- 5) Are not paid by the Federal Government under another Federal award, except where the federal statute authorizing a program specifically provides that Federal funds made available for such program can be applied to matching or cost sharing requirements of other Federal programs;
- 6) Are provided for in the approved budget when required by the federal awarding agency; and
- 7) Conform to other provisions of the law or terms and conditions of the federal award, as applicable.

Legal Reference: 2 C.F.R. § 200.306.

Compensation: Compensation for personal services includes all remuneration for services of employees rendered during the period of performance under the federal award, including, but not limited to wages, salaries, and fringe benefits. Costs of compensation may be allowable under federal law and the federal grant to the extent that they satisfy the following requirements:

- 1) Is reasonable for the services rendered; and
- 2) Conforms to the established written expectations of the District, as applied consistently to both Federal and non-Federal activities.

If the District intends to charge compensation to federal awards, such charges will be based on records that accurately reflect the work performed, and will:

- 1) Be supported by a system of internal control which provides reasonable assurance that the charges are accurate, allowable, and properly allocated;
- 2) Be incorporated into the official records of the District;
- 3) Reasonably reflect the total activity for which the employee is compensated by the District, not exceeding 100% of compensated activities;
- 4) Encompass both federally-assisted and all other activities compensated by the District on an integrated basis, but may include the use of subsidiary records as defined in the District's written procedures;
- 5) Comply with the established accounting policies and practices of the District; and

- 6) Differentiate and account for the distribution of the employee's salary or wages among specific activities or cost objectives if the employee works on more than one Federal award; a Federal award and non-Federal award; an indirect cost activity and a direct cost activity; two or more indirect activities which are allocated using different allocation bases; or an unallowable activity and a direct or indirect cost activity.

Budget estimates will generally not be used to support charges to Federal awards but may be used for interim accounting purposes.

Legal Reference: 2 C.F.R. §§ 200.430 & 200.431.

Unexpected or Extraordinary Circumstances: For all federal awards, if the District does not currently have in place a sufficient policy that addresses extraordinary circumstances, such as those caused by COVID-19, the District may amend or create a policy at a later date in order to put emergency contingencies in place for federal and non-federal similarly situated employees. If the conditions exist for charges to be made to the federal grant, then charges may also be made to any non-federal sources that are used by the District in order to meet a matching requirement. The District will take other steps to comply with federal award requirements in the event of unexpected or extraordinary circumstances.

Legal Reference: 2 C.F.R. §§ 200, et seq.

Approved: 08/09/2021                      Reviewed: \_\_\_\_\_                      Revised: \_\_\_\_\_

HASTINGS PUBLIC SCHOOLS



# A MODERN TOOL OFFERING MORE EFFECTIVE TEACHING, COMMUNICATION AND DATA ANALYSIS

Student Information System  
(SIS)

**Edupoint**<sup>®</sup>

 **Synergy**<sup>®</sup>  
Education Platform

# Hastings Public Schools Synergy

## Why change?

- Hasting Public Schools has used PowerSchool as our Student Information System (SIS) since 2001 but there are features it is lacking or that are expensive to have added.
- There is a another SIS option we have been exploring since 2019. We considered bringing this to the School Board last year but due to Covid-19 we waited.
- This other SIS is called Synergy by Edupoint which offers several features at a more affordable price than we could get with PowerSchool and has options that PowerSchool does not have available.
- Synergy is a modern, user-friendly database which could replace PowerSchool , and provide HPS with additional benefits.

# Hastings Public Schools Synergy

## What do we need from a Student Information System?

- High Stakes Data needs to be reported to the Nebraska Department of Education (NDE) from a SIS vendor.
- PowerSchool & Synergy are 2 of the 6 NDE certified SIS vendors in Nebraska.
- All student data that is sent to NDE goes through these SIS vendors and it is from this data that each District's State Aid is calculated.
- During the 2020-2021 school year Synergy was presented to 4 different subgroups of HPS Staff: Teachers, Counselors, Secretaries & Administrator. Over 90% of the staff it was presented to liked what they saw, feeling it looked easy to use, had useful reports and features we do not have currently with PowerSchool to improve student success.

# Hastings Public Schools Synergy

## What is the benefit to parents?

### Online Registration

- Reduction in the amount of PAPER forms
  - Annual census cards, kindergarten registrations, summer school, health, lunch, EL, Special Ed, transportation, camps, etc.
  - Can be accessed and filled out on a computer, tablet, or smartphone.
  - Update all of their family's student data at one time from any device.

We do not currently have an Online Registration option.

Line	Registration Date	Student	Grade Totals			Registering Parent	Note	School Selection(s)	In Boundary	Disc	Health	Registration Flags		
			Grade	Currently Enrolled	Max							Programs	Status	
1	11/01/2013	Fransome, Kris	11	873	871	Fransome, Jerry	Enter a Note	Hope High School ✓ In School Boundary	✓					
2	11/01/2013	Terry, Tami	11	873	871	Thibet, Ron	Enter a Note	Hope High School ✓ In School Boundary	✓					
3	11/10/2013	Zelwig, Abbey	11	873	871	Zelwig, Yathron	Enter a Note	Hope High School ✓ In School Boundary						
4	05/19/2016	Zipperer, Russell L.	12	826	825	Zipperer, Ernest	Enter a Note	Hope High School						
5	01/09/2017	Zehring, Shawn P.	11	873	871	Zehring, Randall	Enter a Note	Hope High School ✓ In School Boundary	✓					
6	08/23/2017	Williams, Bryce L.	09	1	1050	Williams, Jerry	Enter a Note	Hope High School ✓ In School Boundary						
7	08/10/2018	Williams, Margaret B.	10	1057	1050	Williams, Catherine	Enter a Note	Hope High School ✓ In School Boundary	✓					

# Hastings Public Schools Synergy

## Automated sharing of information

Improved Accuracy and Efficiency: sharing information with appropriate staff and helping to reduce paper forms.

- Built-in “workflow” that can alert staff of things they need to know about a student:
  - Parent says a student has a food allergy? The nurse and food services can receive a message.
  - Parent says a student has an IEP? The Special Education department can receive a message.
  - Parent says the student does not speak English? The English Language department can receive a message.
  - Parent says the student is interested in football? The coach can receive a message to follow up.

We do not currently have this type of automated “workflow” option.

# Hastings Public Schools Synergy

## Improved Communication

### Overcome language barriers

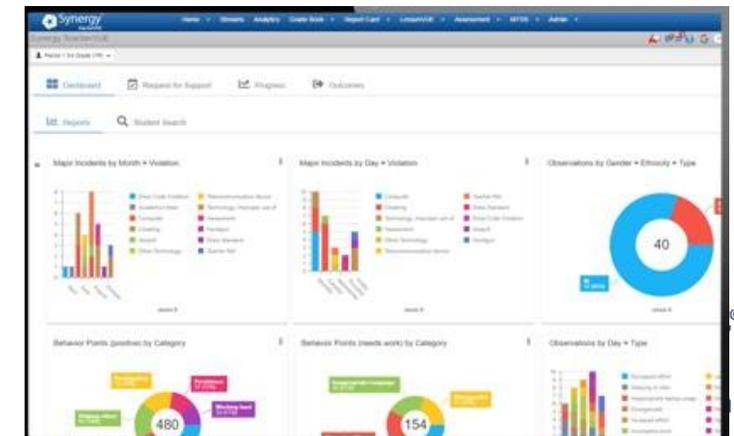
- improve relations and increase parent participation.
  - Currently to communicate with more stakeholders the district has to enlist a bi-lingual staff to assist in translation and unfortunately this is primarily only available for Spanish speakers.
- **Multi-Language Translation**
  - online or on a mobile app – parents & students can see student information in their native language and send & receive emails in their native language.
- Teachers can communicate directly from Gradebook.
- Synergy includes Google Classroom Integration & direct link to Zoom

We do not currently have a language translation option.

# Hastings Public Schools Synergy

## Multi-Tiered System of Supports (MTSS) and Special Education Data

- Students benefit from a MTSS approach for academic and behavioral challenges.
- Our grants require data and incorporating an MTSS program can streamline this data to effectively and efficiently problem-solve.
- With built in reports and graphs, teachers can set student goals and expectations to help students meet daily tasks and develop accountability.
- Also Special Education data is integrated with Synergy = less duplication of data.



# Hastings Public Schools Synergy



## Mobile Access

- Students and Parents
  - View grades, see when assignments are due, communicate with teachers, submit assignments, school announcements and reminders, etc.
- Teachers/Counselors - NEW and something we do not currently have
  - Take attendance, create assignments/enter scores, submit discipline incident referrals, view student demographic information, communicate with parents and more.
- Administrators - NEW and something we do not currently have
  - Scan student IDs to quickly access student records, mark students tardy, print hall passes and record discipline issues.
  - In case of emergency, they may also activate a digital emergency management protocol that notifies teachers, accounts for students, and informs first responders.

# Hastings Public Schools Synergy

## Proposed Timeline

Continue with PowerSchool for the 2021-2022 school year while converting the PowerSchool data over to Synergy.

**Synergy has developed a 5 phase process for implementation accuracy.**

- Phase 1 – planning – completed Aug 2021
- Phase 2 – preparing the data - completed Sept 2021
- Phase 3 – testing the data and performing quality assurance – completed May 2022
- Phase 4 – deploying Synergy – completed July 2022
- Phase 5 – go live with Synergy and no longer use PowerSchool – completed Aug 2022
- Support and Maintenance – ongoing from Synergy and ESU 9

\*ESU 9 has agreed to partner with Synergy and Hastings Public Schools from implementation to completion with ongoing local support.

\*Synergy has a proven track record for converting PowerSchool data into their system

# Hastings Public Schools Synergy

## Cost of PowerSchool vs. Synergy

- Current base price for PowerSchool is approximately \$33,000 per year.
- Base price for Synergy would be approximately \$40,000 per year.
  
- PowerSchool + on line forms & registration + MTSS + Special Ed data = \$68,000 per year
- Synergy + on-line forms & registration + MTSS + Special Ed data = \$57,000 per year
  
- One year set up cost for Synergy is approximately \$37,000. (Note: ESU 9 will provide \$40,000 to HPS for Synergy)
- Cost of Synergy covered by ESSER for the next three years

# Hastings Public Schools Synergy

- Hastings Public Schools wants to continue to improve PK-12 Student Data & Learning for the future. New tools are available with Synergy.
- ESU 9's agreement to a partnership with Synergy and Hastings Public Schools is an advantage.
- Synergy is currently serving 5 Million Students in 22 States. Founded in 2003.
- Synergy has been successfully adopted in several larger Nebraska school districts already.
  - Lincoln Public Schools
  - South Sioux City Schools
  - Grand Island Public Schools
  - Millard Public Schools
  - Columbus Public Schools
- **QUESTIONS?**

## **PERSONNEL**

### **Certificated Staff Resignation – Sarah Bernard-Stevens**

The administration recommends acceptance of the following Certificated appointment(s):

Sarah Bernard-Stevens resigned from her Instrumental Music Teacher position effective the end of the 2020-2021 school year. Ms. Bernard-Stevens was under a one-year contract to cover a long-term absence for Rick Matticks. Ms. Bernard-Stevens will continue as a long-term substitute for the remainder of Mr. Matticks' absence during the 2021-2022 school year.

### **Extra Standard Appointments – Abbi Haynes, Jenna Jorgensen**

The administration recommends the following Extra Standard appointment(s):

Abbi Haynes to 8<sup>th</sup> Grade Assistant Volleyball at Middle School to replace Peg Johnson who resigned. Ms. Haynes will be paid the MS Volleyball stipend of \$1,780.00 at Category I, Level 1 according to the 2021-2022 extra standard salary schedule.

Jenna Jorgensen to Teammates Coordinator (1/2 split) position at Middle School to replace Sara Ostdiek who resigned. Ms. Jorgensen will be paid the Teammates Coordinator (1/2 split) stipend of \$2,492.00 at Category V, Level 1 according to the 2021-2022 extra standard salary schedule.

### **Classified Staff Releases/Resignations/Retirements – Melissa Cowling, Ronna McEntee**

The administration recommends acceptance of the following classified retirement(s)/resignation(s):

Melissa Cowling resigned from Special Education Para position at Middle School effective the end of the 2020-2021 school year.

Ronna McEntee resigned from Secretary position at Senior High effective June 30, 2021.

### **Classified Staff Transfer(s) – Brenda Kuehn**

The administration recommends acceptance of the following Classified transfer(s):

Brenda Kuehn from Office Paraeducator position to Secretary 10 position at Longfellow to replace Glenda McMurray who is retiring. Ms. Kuehn's wage and hours will be adjusted for the new assignment according to the 2021-2022 classified salary schedule.

### **Classified Staff Appointments – Shayla Dunn, Rachel Guiai, William King**

The administration recommends the following Classified appointment(s):

Shayla Dunn to Human Resources Secretary position at Administration Office to replace Jill Kleier who resigned. Ms. Dunn will be paid the starting wage for Director's Secretary according to the 2020-2021 classified salary schedule, with adjustment for education and experience. Information about Ms. Dunn is attached.

Rachel Guiai to Special Education Skills 2 Paraeducator position at Middle School to replace Rebecca Niles who resigned. Ms. Guiai will be paid the starting wage for Special Education Skills Paraeducator according to the 2021-2022 classified salary schedule, with adjustment for education and/or prior experience. Information about Ms. Guiai is attached.

William King to Evening Custodian position at Middle School/Watson to replace Jasmine Kennedy who transferred to another position. Mr. King will be paid the starting wage for Evening Custodian according to the 2021-2022 classified salary schedule, with adjustment for education and/or prior experience. Information about Mr. King is attached.