Madison Central School District

7303 State Route 20, Madison, NY 13402
315-893-1878 • 315-893-7111 Fax
madisoncentralny.org

BOARD OF EDUCATION
AUDIT COMMITTEE MEETING
REGULAR MEETING

OCTOBER 19, 2021
6:00 P.M. - AUDITORIUM
6:30 P.M. – AUDITORIUM

I. Call to Order

II. Audit Review
   a. David Brownell of Mostert, Manzanero & Scott, LLP, Certified Public Accountants, presenting the 2020-2021 Fiscal Year Audit

III. Adjourn Audit Committee Meeting

IV. Call to Order of Regular Meeting

V. Agenda Additions

VI. Consent Agenda
   a. Approval of Agenda for This Meeting
   b. Approval of Minutes
      1. September 21, 2021 Regular Meeting Minutes

VII. Public Forum

VIII. Reports
   a. Treasurer
      1. Internal Claims Auditor's Report
      2. Treasurer's Report dated September 30, 2021
      3. Detail Warrants
         a. Warrant Number 9 - Fund A - 9/2/21 - 3 pages
         b. Warrant Number 10 - Fund A - 9/17/21 - 7 pages
         c. Warrant Number 5 - Fund C - 9/17/21 - 2 pages
         d. Warrant Number 3 - Fund TA - 10/11/12 - 4 pages
         e. Warrant Number 5 - Fund FA21 - 9/2/21 - 1 page
         f. Warrant Number 1 - Fund FA22 - 9/17/21 - 1 page
      4. Financial Status Report
      5. Quarterly Student Activities Reports July-September 2021

b. Superintendent – Information Items
    1. COVID 19
        a. Testing
        b. Cases
    2. National FFA Convention

c. Superintendent – Approval Items
    1. Approval of increase in pay rates due to minimum wage increase effective January 1, 2022
    2. Approval of MOA with Non-Instructional Unit
    3. Acceptance of 2020 Annual Drinking Water Quality Report

IX. Committee Reports

X. Policy
a. Second Readings and Approvals of:
    1. Policy #2300 entitled "Regular Board Meetings"
    2. Policy # 2400 entitled "Formulation, Adoption and Dissemination of Policy"
b. Notice of Superintendent Approval of Regulations due to expiration of previous forms
    1. Regulation # 6300.2 entitled Notice of Eligibility & Rights and Responsibilities under the Family and Medical Leave Act
    2. Regulation # 6300.3 entitled Certification of Health Care Provider for Employee's Serious Health Condition under the Family and Medical Leave Act
    3. Regulation # 6300.4 entitled Certification for Military Family Leave for Qualifying Exigency under the Family and Medical Leave Act
    4. Regulation # 6300.5 entitled Certification of Health Care Provider for Family Member's Serious Health Condition under the Family and Medical Leave Act

XI. Old Business

XII. Board of Education Discussion Items

XIII. New Business
a. Personnel
    1. Appointments
        a. Substitute Teacher Appointments expected next week
    2. Retirements
        a. Lorrie Gridley - Food Service effective June 30, 2022
    3. Salary Adjustments
        a. Bridget Idzi - from M1 with Masters, Step 20 to M3 with Masters, Step 20
        b. Jessica Palmer - from M1 with Masters, Step 7 to M4 with Masters, Step 7
    4. Leave Request
        a. Jessica Chenel - FMLA starting Friday, October 29, 2021 though January 28, 2022 utilizing sick time and unpaid leave
    5. Mentor Appointments
        a. ***for Michael Barnes with a stipend of $100

b. CSE/CPSE Recommendations – in official packet

c. Principal / Director Reports

XIV. Correspondence

XV. Question & Answer Opportunity

XVI. Adjournment

The Regular Meeting of the Board of Education of Madison Central School was held on September 21, 2021 at 6:30 pm in the auditorium.

MEMBERS PRESENT: Mrs. Laura Billings
Mrs. Jessica Clark
Mr. Mike Filipovich
Mrs. Jennifer Lavoie
Mrs. Brittany Rizzo
Mr. Jona Snyder
Ms. Jennah Turner

MEMBERS ABSENT: None

OTHERS PRESENT: Mr. Jason Mitchell, Superintendent
Mrs. LeeAnn Cucci, Elementary Principal
Mr. Larry Nichols, MS/HS Principal
Mr. Brian Latella, Director of Curriculum
Mrs. Melanie Brouillette, Treasurer
Ms. Tracey Lewis, District Clerk

I. Call to Order
   a. Mrs. Lavoie, president, called the meeting to order at 6:34 pm.

II. Agenda Additions

III. Consent Agenda
   a. Approval of Agenda for This Meeting

MOTION # 1 - APPROVAL OF AGENDA
ON THE MOTION of Mr. Snyder, seconded by Mrs. Billings, the Board moved to approve the agenda for this meeting. Motion carried 7 yes, 0 no.

   b. Approval of Minutes
      1. August 30, 2021 Special Meeting Minutes

MOTION # 2 - APPROVAL OF MINUTES
ON THE MOTION of Mrs. Turner, seconded by Mr. Snyder, the Board moved to approve the minutes from the August 30, 2021 Special Meeting. Motion carried 7 yes, 0 no.

IV. Public Forum
   a. None

V. Presentation
   a. Mr. Hill did a presentation on the success and adventures of the Summer LEAP Program with assistance from Mrs. Millson.

VI. Reports

a. Treasurer

1. Internal Claims Auditor's Report - updated 9/17/21

MOTION # 3 - APPROVAL OF INTERNAL CLAIMS AUDITOR'S REPORT

ON THE MOTION of Mr. Filipovich, seconded by Mr. Snyder, the Board moved to approve the Internal Claims Auditor's Report. Motion carried 7 yes, 0 no.

2. Treasurer's Report dated July 31, 2021
3. Treasurer's Report dated August 31, 2021

MOTION # 4 - APPROVAL OF TREASURER'S REPORTS

ON THE MOTION of Mrs. Turner, seconded by Mrs. Rizzo, the Board moved to approve the July 31, 2021 and the August 31, 2021 Treasurer's Reports. Motion carried 7 yes, 0 no.

4. Detail Warrants

MOTION # 5 - APPROVAL OF DETAIL WARRANTS

ON THE MOTION of Mr. Filipovich, seconded by Mr. Snyder, the Board moved to approve the Detail Warrants as follow: Warrant Number 5 - Fund A - 8/6/21 - 3 pages, Warrant Number 6 - Fund A - 9/13/21 - 1 page, Warrant Number 7 - Fund A - 8/20/21 - 4 pages, Warrant Number 1 - Fund C - 8/6/21 - 1 page, Warrant Number 3 - Fund C - 9/13/21 - 1 page, Warrant Number4 - Fund C - 8/20/21 - 1 page, Warrant Number 2 - Fund TA - 9/13/21 - 2 pages, Warrant Number 2 - Fund FA21 - 8/6/21 - 1 page, Warrant Number 3 - Fund FA21 - 8/20/21 - 1 page, Warrant Number 4 - Fund FA21 - 9/13/21 - 1 page. Motion carried 7 yes, 0 no.

5. The Financial Status Report was shared.

b. Superintendent – Information Items

1. The notice of the SBI workshop for September 23, 2021 entitled "COVID 19 Federal Funding: Challenges and Opportunities was shared.
2. The notice that the Madison Oneida BOCES will be filling the Board vacancy by appointment for Hamilton Central School due to resignation of the current representative was shared.
3. Mr. Mitchell discussed the COVID-19 Screen testing process. All unvaccinated employees will be required to test starting September 30, 2021. At this time there are also approximately 40 students interested in participating in the weekly testing as well. The testing is a "pool test" consisting of 12 samples. If that pool comes back negative, those participants in that pool are considered negative. If the pool comes back positive, individual testing will be done on those 12 samples within that pool to determine which sample is positive and necessary notification, tracing and quarantining will be done for that individual.
4. MCS will hold another volunteer work day for the Discovery Trail on Saturday, September 25, 2021. The District would love to see as many student volunteers and community volunteers as possible.
5. The FFA would like consideration to attend the FFA National Convention in Indianapolis, IN from October 26 through November 2, 2021. Mr. Mitchell discussed his concerns, related to COVID-19 protocols, with the Board at this time.

c. Superintendent – Approval Items

1. FFA Trip to FFA National Convention

MOTION # 6 - APPROVAL OF FFA TRIP WITH CONTINGENCIES
ON THE MOTION of Mr. Snyder, seconded by Mrs. Turner, the Board moved to approve Mr. Mitchell to make the final approval for the participation in the FFA National Convention overnight trip from October 26 through November 2, 2021, specifically pending the availability of enough hotel rooms to allow only 2 students per room in light of the COVID-19 situation now and at the time of the trip. Other requirements may be placed in effect by the Superintendent for final approval. Motion carried 7 yes, 0 no.

2. DCIP - District Comprehensive Improvement Plan
3. SCEP - School Comprehensive Education Plan

MOTION # 7 - APPROVAL OF THE DCIP AND THE SCEP
ON THE MOTION of Mrs. Billings, seconded by Mrs. Rizzo, the Board moved to approve the DCIP (District Comprehensive Improvement Plan) and the SCEP (School Comprehensive Education Plan). Motion carried 7 yes, 0 no.

4. Approval of LEAD evaluators

MOTION # 8 - APPROVAL OF LEAD EVALUATORS
ON THE MOTION of Mr. Filipovich, seconded by Mrs. Billings, the Board moved to approve Jason Mitchell, Brian Latella, Larry Nichols and LeeAnn Cucci as LEAD Evaluators. Motion carried 7 yes, 0 no.

5. Approval of Non Resident Student for 2021-22
   a. Student entering grade 3

MOTION # 9 - APPROVAL OF NON RESIDENT STUDENT
ON THE MOTION of Mr. Snyder, seconded by Mrs. Billings, the Board moved to approve the Non-Resident Student application for a student entering grade 3 for the 2021-22 school year. Motion carried 7 yes, 0 no.

6. Approval to surplus a Vision Tester

MOTION # 10 - APPROVAL TO SURPLUS VISION TESTER
ON THE MOTION of Mrs. Rizzo, seconded by Mrs. Turner, the Board moved to approve the surplus of a vision tester. Motion carried 7 yes, 0 no.

7. Approval to surplus books as per list

MOTION # 11 - APPROVAL TO SURPLUS BOOKS
ON THE MOTION of Mrs. Turner, seconded by Mrs. Billings, the Board moved to approve the surplus of books as per list. Motion carried 7 yes, 0 no.

8. Approval to surplus library books as per list

MOTION # 12 - APPROVAL TO SURPLUS LIBRARY BOOKS
ON THE MOTION of Mr. Snyder, seconded by Mrs. Turner, the Board moved to approve the surplus of Library Books as per list. Motion carried 7 yes, 0 no.

9. Approval of tax adjustment for Tax Map #114.19-1-21

MOTION # 13 - APPROVAL OF TAX ADJUSTMENT
ON THE MOTION of Mrs. Rizzo, seconded by Mrs. Turner, the Board moved to approve the tax adjustment for tax map # 114.19-1-21. Motion carried 7 yes, 0 no.

10. Approval of creation of Temporary One Year School Nurse position for the 2021-22 school year

MOTION # 14 - APPROVAL OF CREATION OF TEMPORARY ONE YEAR SCHOOL NURSE POSITION

ON THE MOTION of Mr. Filipovich, seconded by Mr. Snyder, the Board moved to approve the creation of a temporary one year School Nurse position. Motion carried 7 yes, 0 no.

VII. Committee Reports
- a. The Policy Committee met and the recommendations are in the Policy section of this agenda.
- b. Mr. Mitchell will begin meetings soon for the Negotiations Committee for the negotiation of the upcoming MTA Contract.
- c. Mr. Mitchell indicated that when the Building Condition Survey is completed that the Buildings and Grounds Committee will also begin meeting.

VIII. Old Business
- a. None

IX. Policy
- a. The first reading of Policy # 2300 entitled "Regular Board Meetings" was done at this time.
- b. The first reading of Policy #2400 entitled "Formulation, Adoption and Dissemination of Policy" was done at this time.
- c. Notice was given of the Superintendent's approval to changes to Regulation #2301.1 entitled "Board Agenda Guidelines".

X. Board of Education Discussion Items
- a. None

XI. New Business
- a. Personnel
  1. Appointments

MOTION # 15 - APPROVAL OF APPOINTMENTS

ON THE MOTION of Mr. Filipovich, seconded by Mrs. Turner, the Board moved to approve the following list of appointments:

- a. Michael Barnes - Long Term Substitute for grades 7-12 Mathematics from approximately September 27, 2021 through June 30, 2021
- b. Jody McKane - Full Time Nurse for One Year position for the 2021-22 school year effective September 20, 2021 prorated as per contract
- c. Mary Witkowski - Certified Substitute Teacher effective September 7, 2021
- d. Kayla Collins - Non Certified Substitute Teacher effective September 20, 2021
- e. Robert Magee - School Psychologist for the 2021-22 school year at $325 per day not to exceed 80 days per academic year
- f. Jennifer Sprinkle - Non Certified Substitute Teacher effective September 21, 2021

Motion carried 7 yes, 0 no.

2. Advisor Appointments for 2021-22

MOTION # 16 - APPROVAL OF ADDITIONAL ADVISORS FOR 2021-22
ON THE MOTION of Mrs. Rizzo, seconded by Mr. Filipovich, the Board moved to approve the following additional advisors for the 2021-22 school year:

a. Class of 2025 - Jennifer Neidhart
b. Class of 2025 - Darcy Schenk
c. Class of 2023 - Amanda Barton

Motion carried 7 yes, 0 no.

3. Retirement
   a. Duane Willsey - Elementary Education Teacher effective June 30, 2021

MOTION # 17 - ACCEPTANCE OF RETIREMENT
ON THE MOTION of Mrs. Clark, seconded by Mrs. Billings, the Board moved to accept the Retirement of Duane Willsey as an Elementary Education Teacher effective June 30, 2021, with thanks . Motion carried 7 yes, 0 no.

4. Mentor Appointments

MOTION # 18 - APPROVAL OF MENTOR APPOINTMENTS
ON THE MOTION of Mrs. Rizzo, seconded by Mrs. Billings, the Board moved to approve the following list of Mentors for the 2021-22 school year:

a. Jessica Mortensen for Corey Zlatniski with a stipend of $100
b. Bridget Idzi for Cassie Head with a stipend of $500
c. Courtney Heim for Kimberly Johnson with a stipend of $100
d. Melissa Nelson for Kelly Diehl with a stipend of $500
e. Brian Latella for LeeAnn Cucci with no stipend
f. Lindsay Murphy for Jennifer Buckley with a stipend of $500
g. Jon Silkowski for Amanda Rossi with a stipend of $500
h. Amanda Hinman for Amber O'Neil with a stipend of $500
i. Tina Bergeron for Allison Leone with a stipend of $500

Motion carried 7 yes, 0 no.

5. Tenure as per Resolution
   a. Lindsay Murphy effective October 7, 2021

MOTION # 19 - APPROVAL OF TENURE
ON THE MOTION of Mrs. Clark, seconded by Mr. Snyder, the Board moved to approve the tenure of Lindsay Murphy as per Resolution effective October 7, 2021. Motion carried 7 yes, 0 no.

b. CSE/CPSE Recommendations – in official packet

MOTION # 20 - APPROVAL OF CSE/CPSE RECOMMENDATIONS
ON THE MOTION of Mrs. Clark, seconded by Mr. Snyder, the Board moved to approve the CSE/CPSE Recommendations as found in the official packet. Motion carried 7 yes, 0 no.

c. Principal / Director Reports

1. Mrs. Cucci, Elementary Principal, spoke about the large attendance at her "Popsicles with the Principal" event and the request to do that again and the success of the Open House. She also spoke about making several changes to the schedules and she believes most of the little glitches have been resolved. She spoke about the "Color Days" and thanked everyone for participating as it not only teaches students their colors, but also increases unity. She thanked Lincoln Davies for the generous donation of tickets to every student in grades PreK-5 to their fall festival and the CreekSide for the donations of hundreds of school supplies. Mrs. Cucci explained that the fall assessments are going on now, but we have a lack of substitutes which has slowed down progress slightly. Lastly she informed the Board that two fire drills have already taken place and the Bus Safety presentation for grades PreK-2 will be next Monday.

2. Mr. Nichols expressed great praise to Mrs. Cucci for all her hard work and job well done acclimating herself to this new position. He said that the Open House was very well attended and he was happy to see so many kids bringing in their supplies and getting their lockers figured out before the first day of school. The students all seem to be very happy to be back in school full time. The Learning Club has started up again on Tuesdays and Thursdays from 3-4 pm with a snack provided from the cafeteria for all those that stay each night. Lastly, he spoke about the progress made with ESports. The goal is to offer more to the student body, engaging those students who may not have interest in the current offerings and not to take away from the in person athletics. It is a project in the works, but making progress.

3. Mr. Latella shared information about the August 30th new teacher orientation day, including the bus trip touring the District with Jim Ford acting as local historian and tour guide and Jona Snyder providing the bus driving. He also discussed the SCEP plan and the large amounts of professional development being offered to the staff. Mr. Latella shared that much studying of data is going on to improve teaching and engagement of students into learning. He applauded Mr. Silkowski for a job well done when announcing all the new staff and thanked the staff for participating in the reading initiative. Mr. Latella also spoke at length about all the new Special Education Teachers coordinating all the needs of the student IEPs as well as the shortage of substitute teachers. Lastly he talked about how the teaching staff is discovering that the students are socially and emotionally behind due to the amount of time they were learning remotely last year and that the staff is working hard at getting the students back on track.

XII. Correspondence
a. None

XIII. Question & Answer Opportunity
a. None

XIV. Adjournment

MOTION # 21 - ADJOURNMENT
ON THE MOTION of Mrs. Rizzo, seconded by Mr. Filipovich, the Board moved to adjourn for the evening at 7:24 pm. Motion carried 7 yes, 0 no.

Athletic Run		$16.05
Field Trip		$16.05
Retired Sub Teacher		$110.00
Sub Teacher- Cert		$105.00
Sub Teacher-Non-Cert		$100.00
Student Helper		$13.20
Detention Monitor		$13.20
Sub Typist		$13.20
Sub Teacher's Aide		$13.20
Sub Cleaner		$13.20
Sub Food Service		$13.20
Snow Plowing		$13.70

MADISON COUNTY DEPARTMENT *of* HEALTH

Eric Faisst, Director of Public Health — *Dr. John B. Endres, President of Board of Health*

March 19, 2021

Village of Madison
P.O. Box 333
7358 State Route 20
Madison, New York 13402-0333
Attn: Barbara Clark, Mayor

Re: 2020 Annual Water Quality Report,
Village of Madison PWS
PWS # NY2602378

Dear Ms. Clark:

Enclosed please find a copy of your 2020 Annual Water Quality Report (AWQR). The Madison County Department of Health (MCDOH) is once again pleased to create these reports on your behalf. Please be reminded that it is your responsibility to:

1. Ensure that the report are accurate and complete.
2. Deliver the 2020 AWQR to your customers and to the NYS Department of Health (NYSDOH) by May 31, 2021.
3. Send completed Certification of Delivery Form to the NYSDOH and MCDOH addresses listed below by September 1, 2021.

Should you find any errors please contact our office at 315-366-2526. If you find that the report is accurate you may begin to distribute it to your customers and forward a copy to the NYSDOH at the address listed below. Delivery of the AWQR to your customers and to the NYSDOH must be completed by May 31, 2021. The enclosed Certification of Delivery must be filled out and returned to both the MCDOH and the NYSDOH no later than September 1, 2021.

Send a copy of your 2020 AWQR and a copy of your Certificate of Delivery to	Send a copy of your Certificate of Delivery to:
NYS Department of Health Attn: Director Bureau of Water Supply Protection Corning Tower, Room 1110 Empire State Plaza Albany, NY 12237 Or email to AWQR@health.ny.gov	Attn: Daniel Peck Public Health Sanitarian Madison County Health Department P.O. Box 605 Wampsville, NY 13163 Or email to Daniel.Peck@madisoncounty.ny.gov

In January 2013, the United States Environmental Protection Agency (USEPA) determined that specific methods of electronic delivery may be used by a community water supplier to meet the regulatory requirement to "mail or otherwise directly deliver" water quality reports, to their bill paying customers. In conformance with the USEPA's efforts, community water systems in New York State may now use electronic delivery as an additional option in order to distribute the AWQR. Guidance regarding the AWQR and specific methods of electronic delivery can be found on the New York State Health Department website at:

http://www.health.ny.gov/environmental/water/drinking/annual_water_quality_report/guidance.htm

Please feel free to contact me at the Madison County Department of Health at 315-366-2526 if you have any questions.

Sincerely,

Daniel Peck
Public Health Sanitarian

Enc. Certificate of Delivery, 2020 AWQR

Cc: AWQR file

Annual Drinking Water Quality Report for 2020
Madison Village
7358 State Route 20
Madison, NY 13402
PWS # NY2602378

INTRODUCTION

To comply with State regulations, the Village of Madison, will be annually issuing a report describing the quality of your drinking water. The purpose of this report is to raise your understanding of drinking water and awareness of the need to protect our drinking water sources. Last year, your tap water met all State drinking water health standards. We are proud to report that our system did not violate a maximum contaminant level or any other water quality standard. This report provides an overview of last year's water quality. Included are details about where your water comes from, what it contains, and how it compares to State standards.

If you have any questions about this report or concerning your drinking water, please contact Mark Lewis, Water Operator, Village of Madison at 315-893-1894. We want you to be informed about your drinking water. If you want to learn more, please attend any of our regularly scheduled village board meetings. The meetings are held the second Wednesday of every month at 7:00 P.M. at the Village Offices.

WHERE DOES OUR WATER COME FROM?

In general, the sources of drinking water (both tap water and bottled water) include rivers, lakes, streams, ponds, reservoirs, springs, and wells. As water travels over the surface of the land or through the ground, it dissolves naturally occurring minerals and, in some cases, radioactive material, and can pick up substances resulting from the presence of animals or from human activities. Contaminants that may be present in source water include: microbial contaminants; inorganic contaminants; pesticides and herbicides; organic chemical contaminants; and radioactive contaminants. In order to ensure that tap water is safe to drink, the State and the EPA prescribe regulations which limit the amount of certain contaminants in water provided by public water systems. The State Health Department's and the FDA's regulations establish limits for contaminants in bottled water which must provide the same protection for public health.

Our water system serves approximately 450 people through 160 service connections. Our water source is a 75-foot drilled well which is located off Solsville Road. Our well water is disinfected with chlorine prior to distribution. We also have a backup spring source, to only be used in the event of an emergency. Approval from the Madison County Department of Health is required prior to the utilization of the spring source. The spring source is not disinfected and is not normally distributed to our customers.

NEW YORK STATE DEPARTMENT OF HEALTH SOURCE WATER ASSESSMENT – GROUNDWATER SOURCE

The NYS DOH has completed a source water assessment for this system, based on available information. Possible and actual threats to this drinking water source were evaluated. The state source water assessment includes a susceptibility rating based on the risk posed by each potential source of contamination and how easily contaminants can move through the subsurface to the wells. The susceptibility rating is an estimate of the potential for contamination of the source water, it does not mean that the water delivered to consumers is, or will become contaminated. See section "Are there contaminants in our drinking water?" for a list of the contaminants that have been detected. The source water assessments provide resource managers with additional information for protecting source waters into the future.

The public water supply serving the Village of Madison is derived from 1 drilled well. The source water assessment has rated this well as having a high to very high susceptibility rating for microbials, a high susceptibility for industrial solvents, a medium-high to high susceptibility for other industrial contaminants, and a very high susceptibility for

nitrates. These ratings are due primarily to the close proximity of permitted discharge facilities (industrial/commercial facilities that discharge wastewater into the environment and are regulated by the state and/or federal government) identified within the assessment area. Based on submitted data, the well draws from fractured bedrock and overlying soils may not provide adequate protection from potential contamination. Please note that, while the source water assessment rates the well as being susceptible to microbials, the water is disinfected to ensure that that the finished water delivered into your home meets the New York State drinking water standards for microbial contamination.

NEW YORK STATE DEPARTMENT OF HEALTH SOURCE WATER ASSESSMENT – SPRING SOURCE:

The NYS DOH has evaluated this PWS's susceptibility to contamination under the Source Water Assessment Program (SWAP), and their findings are summarized in the paragraph(s) below. It is important to stress that these assessments were created using available information and only estimate the potential for source water contamination. Elevated susceptibility ratings do not mean that source water contamination has or will occur for this PWS. This PWS provides does not provide treatment and regular monitoring for this emergency use source. This assessment found an elevated susceptibility to contamination for this emergency source of water. The amount of agricultural and residential lands in the assessment area results in elevated potential for microbials, phosphorus, DBP precursors, and pesticide contamination. While there are some facilities present, permitted discharges do not likely represent an important threat to source water quality, there are no noteworthy contamination threats associated with other discrete contaminant sources. Finally it should be noted that underground water flows to springs could make water sources highly sensitive to existing and new sources of contamination from solvents and petroleum products. In the event that we will be required to distribute water from our emergency spring source we will be required to issue a boil water order for all residents serve by the water system. If you have any questions or concerns regarding the Source Water Assessments or if you would like to review it please feel free to contact the Madison County Department of Health at 315-366-2526

ARE THERE CONTAMINANTS IN OUR DRINKING WATER?

As the State regulations require, we routinely test your drinking water for numerous contaminants. These contaminants include: total coliform, inorganic compounds, nitrate, lead and copper, volatile organic compounds, total trihalomethanes, haloacetic acids, radiological and synthetic organic compounds. The table presented below depicts which compounds were detected in your drinking water. The State allows us to test for some contaminants less than once per year because the concentrations of these contaminants do not change frequently. Some of our data, though representative, are more than one year old. It should be noted that all drinking water, including bottled drinking water, may be reasonably expected to contain at least small amounts of some contaminants. The presence of contaminants does not necessarily indicate that water poses a health risk. More information about contaminants and potential health effects can be obtained by calling the EPA's Safe Drinking Water Hotline (800-426-4791) or the Madison County Health Department at 315-366-2526.

Table of Detected Contaminants

Contaminant	Violation Yes/No	Date of Sample	Level Detected Avg/Max (Range)	Unit	MCLG	Regulatory Limit (MCL, TT or AL)	Likely Source of Contamination
Inorganic Contaminants							
Nitrate	No	2/18/20	3.51	ppm	10	10	Runoff from fertilizer and erosion from natural deposits.

Contaminant	Violation Yes/No	Date of Sample	Level Detected Avg/Max (Range)	Unit	MCLG	Regulatory Limit (MCL, TT or AL)	Likely Source of Contamination
Inorganic Contaminants							
Copper **See footnote #1**	No	9/4/19-9/5/19	0.153 Range (ND-0.161)	ppm	1.300	AL = 1.300	Corrosion of household plumbing systems; Erosion of natural deposits; leaching from wood preservatives.
Lead **See footnote #4**	No	9/4/19-9/5/19	1.3 Range (ND-1.5)	ppb	0	AL= 15	Corrosion of household plumbing systems; Erosion of natural deposits.
Sodium **See footnote #2**	No	2/18/20	115	ppm	N/A	20	Erosion of natural deposits; water softeners, animal wastes, road salt.
Barium	No	5/13/20	0.281	ppm	2.0	2.0	Discharge of drilling wastes; Discharge from metal refineries; Erosion of natural deposits.
Disinfection By-Products							
Total Haloacetic Acids	No	8/13/20	9.2	ppb	N/A	60	By-product of drinking water chlorination needed to kill harmful organisms.
Total Trihalo-methanes	No	8/13/20	1.3	ppb	N/A	80	By-product of drinking water chlorination needed to kill harmful organisms. TTHMS are formed when source water contains large amounts of organic matter.

Contaminant	Violation Yes/No	Date of Sample	Level Detected Avg/Max (Range)	Unit	MCLG	Regulatory Limit (MCL, TT or AL)	Likely Source of Contamination
Organic Contaminants							
Methylene Chloride **See footnote # 3**	No	11/27/17	2.5	ppb	N/A	5	Used as a solvent in paint strippers, as a propellant in aerosols, as a process solvent in the manufacturing of drugs, as a metal cleaning and finishing solvent

Footnotes:

1 – The level presented represents the 90th percentile of the 5 sites tested. A percentile is a value on a scale of 100 that indicates the percent of a distribution that is equal to or below it. The 90th percentile is equal to or greater than 90% of the lead and copper values detected at your water system. In this case, five samples were collected at your water system and the 90th percentile value was 0.18 ppm for copper. The action level for copper was not exceeded at any of the sites tested.

2 – Water containing more than 20 ppm of sodium should not be used for drinking by people on severely restricted sodium diets. Water containing more than 270 ppm of sodium should not be used for drinking by people on moderately restricted sodium diets.

3 – Methylene Chloride was detected in the water sample and in the blank that traveled with the sample. A second water sample was tested for Methylene Chloride on 2/27/2018 and none was detected.

4- The level presented represents the 90th percentile of the 5 sites tested. A percentile is a value on a scale of 100 that indicates the percent of a distribution that is equal to or below it. The 90th percentile is equal to or greater than 90% of the lead and copper values detected at your water system. In this case, five samples were collected at your water system and the 90th percentile value was 1.3 ppb for lead. The action level for lead was not exceeded at any of the sites tested.

Definitions:

Maximum Contaminant Level (MCL): The highest level of a contaminant that is allowed in drinking water. MCLs are set as close to the MCLGs as feasible.

Maximum Contaminant Level Goal (MCLG): The level of a contaminant in drinking water below which there is no known or expected risk to health. MCLGs allow for a margin of safety.

Maximum Residual Disinfectant Level (MRDL): The highest level of a disinfectant allowed in drinking water. There is convincing evidence that addition of a disinfectant is necessary for control of microbial contaminants.

Maximum Residual Disinfectant Level Goal (MRDLG): The level of a drinking water disinfectant below which there is no known or expected risk to health. MRDLGs do not reflect the benefits of the use of disinfectants to control microbial contamination.

Action Level (AL): The concentration of a contaminant which, if exceeded, triggers treatment or other requirements which a water system must follow.

Non-Detects (ND): Laboratory analysis indicates that the constituent is not present.

Milligrams per liter (mg/l): Corresponds to one part of liquid in one million parts of liquid (parts per million - ppm).

Micrograms per liter (ug/l): Corresponds to one part of liquid in one billion parts of liquid (parts per billion - ppb).

Picocuries per liter (pCi/L): A measure of the radioactivity in water.

Not Applicable (N/A): A MCLG is not applicable for this contaminant.

WHAT DOES THIS INFORMATION MEAN?

As you can see by the table, our system had no violations. We have learned through our testing that some contaminants have been detected; however, these contaminants were detected below the level allowed by the State. We are required to present the following information on lead in drinking water:

If present, elevated levels of lead can cause serious health problems, especially for pregnant women, infants, and young children. It is possible that lead levels at your home may be higher than at other homes in the community as a result of materials used in your home's plumbing. The Village of Madison is responsible for providing high quality drinking water, but cannot control the variety of materials used in plumbing components. When your water has been sitting for several hours, you can minimize the potential for lead exposure by flushing your tap for 30 seconds to 2 minutes before using water for drinking or cooking. If you are concerned about lead in your water, you may wish to have your water tested. Information on lead in drinking water, testing methods, and steps you can take to minimize exposure is available from the Safe Drinking Water Hotline (1-800-426-4791) or at http://www.epa.gov/safewater/lead.

IS OUR WATER SYSTEM MEETING OTHER RULES THAT GOVERN OPERATIONS?

During 2020, our system was in compliance with applicable State drinking water operating, monitoring and reporting requirements.

DO I NEED TO TAKE SPECIAL PRECAUTIONS?

Although our drinking water met or exceeded state and federal regulations, some people may be more vulnerable to disease causing microorganisms or pathogens in drinking water than the general population. Immuno-compromised persons such as persons with cancer undergoing chemotherapy, persons who have undergone organ transplants, people with HIV/AIDS or other immune system disorders, some elderly, and infants can be particularly at risk from infections. These people should seek advice from their health care provider about their drinking water. EPA/CDC guidelines on appropriate means to lessen the risk of infection by Cryptosporidium, Giardia and other microbial pathogens are available from the Safe Drinking Water Hotline (800-426-4791).

WHY SAVE WATER AND HOW TO AVOID WASTING IT?

Although our system has an adequate amount of water to meet present and future demands, there are a number of reasons why it is important to conserve water:

- Saving water saves energy and some of the costs associated with both of these necessities of life;
- Saving water reduces the cost of energy required to pump water and the need to construct costly new wells, pumping systems and water towers; and
- Check your toilets for leaks by putting a few drops of food coloring in the tank, watch for a few minutes to see if the color shows up in the bowl. It is not uncommon to lose up to 100 gallons a day from one of these otherwise invisible toilet leaks. Fix it and you save more than 30,000 gallons a year.

CLOSING

Thank you for allowing us to continue to provide your family with quality drinking water this year. In order to maintain a safe and dependable water supply we sometimes need to make improvements that will benefit all of our customers.

Draft 09/14/21

SCHOOL BOARD OPERATIONS 2300

REGULAR BOARD MEETINGS

I. All Board of Education meetings must be open to the public except those portions of the meetings which qualify as executive sessions. A "meeting" is defined as an official convening of a public body for the purpose of conducting public business and a "public body" is defined as an entity of two (2) or more persons which requires a quorum to conduct public business, including committees and subcommittees.

Whenever such meeting is to take place, there must be at least seventy-two (72) hours advance notice in accordance with the provisions of the Open Meetings Law. Notice of other meetings shall be given as soon as is practicable in accordance with law.

If videoconferencing is used to conduct a meeting, the public notice for the meeting shall inform the public that videoconferencing will be used, identify the locations for the meeting, and state that the public has the right to attend the meeting at any of the locations.

Regular monthly meetings of the Board of Education of Madison Central School District shall take place on the day and time designated by the Board at the Organizational Meeting, except as modified at subsequent meetings of the Board.

It is the responsibility of the Superintendent to prepare the agenda and review it with the Board President and Vice President ~~(consistent with Policy 2301)~~ for each meeting of the Board. The agenda for each meeting shall be prepared during the week prior to the meeting. The agenda shall be distributed to Board members no later than the Friday before such regular meeting. Whenever the President or other members of the Board wish to bring a matter to the attention of the Board, such request should be made to the Superintendent so that the same can be placed on the agenda. Whenever individuals or groups wish to bring a matter to the attention of the Board, such request shall be addressed to the Superintendent. The Superintendent shall present such matter to the Board.

II. The Clerk of the Board of Education shall notify the members of the Board of Education in advance of each regular meeting. Such notice, in writing, shall include an agenda and the time of the meeting.

III. In the event that a meeting date falls on a legal holiday, interferes with other area meetings, or there is an inability to attend the meeting by Board members to the extent that a quorum would not be present, the Board shall select a date for a postponed meeting at the previous regular meeting, and shall direct the Clerk to notify all members.

IV. Any meeting of the Board may be adjourned to a given future date and hour if voted by a majority of the Board present.

REGULAR BOARD MEETINGS

V. The Superintendent and members of his/her staff at the Superintendent's discretion shall attend all meetings of the Board. The Superintendent shall attend all executive session meetings of the Board except those that concern his/her evaluation, employment status, and salary determination. The Board may request the attendance of such additional persons as it desires.

Madison Central School District
Legal Ref.: Education Law, 01/25/05 Sections 1708, 1709, 2504
Adopted: 1984, 10/16/98, 01/25/05
Revised: 08/20/13, _____

Draft 09/15/21

SCHOOL BOARD OPERATIONS 2400

FORMULATION, ADOPTION AND DISSEMINATION OF POLICY

I. Policy Statement

Board Policies are adopted by the Board of Education to provide an operational framework for the Madison Central School District. They should be broad enough to permit discretionary action by the Superintendent in meeting day to day events, yet be specific enough to give clear guidance. Administrative Regulations are the detailed directions developed by the Superintendent to implement policy.

II. Formulation, Adoption and Dissemination

A. It is the duty of the Board to adopt, revise or rescind policies. The Board shall generally seek the ideas, opinions and counsel of staff members, administrators and/or citizens in the development of policies before their adoption. The formal adoption of policies shall be recorded in the minutes of the Board. Only those written statements so adopted and so recorded shall be regarded as official Board Policy.

B. The adoption of a written policy shall occur only after review and discussion at a first reading the first reading of the Board of Education and the proposal has been moved, discussed and voted on affirmatively at ~~two successive meetings~~ the second reading of the Board of Education. The policy draft may be amended at the second meeting. ~~(i.e. the "first reading" and the "second reading")~~ By a majority vote, the Board may waive the second reading and complete the adoption of the proposed policy at its first reading.

C. The formal adoption or dissemination of written Board policy shall be recorded in the official minutes of the Board. Such written Board policy shall be the continuing legal regulations of the District.

III. Administrative Regulations

The Madison Central School District Board of Education empowers the Superintendent with the authority to establish administrative regulations, as needed, in order to implement policies and provide detailed direction for the orderly operation of the District.

IV. In the absence of policy, the Superintendent shall have the authority to act. The Superintendent's actions shall be subject to review by the Board.

V. The Superintendent is given the continuing commission of calling to the Board's attention all policies that are out-of-date or for other reasons appear to need revision.

Madison Central School District
Legal Ref: NYS Education Law 1709
Adopted: 1984, 10/16/98
Revised: 01/13/05, 08/20/13

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

U.S. Department of Labor
Wage and Hour Division

WHD 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.

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 1st - December 31st)
- ☐ 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.

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.

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

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.

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)*

Definitions of a Serious Health Condition *(See 29 C.F.R. §§ 825.113-.115)*

Inpatient Care

- An overnight stay in a hospital, hospice, or residential medical care facility.
- Inpatient care includes any period of incapacity or any subsequent treatment in connection with the overnight stay.

Continuing Treatment by a Health Care Provider (any one or more of the following)

Incapacity Plus Treatment: 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:

- 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,
- 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.

Pregnancy: Any period of incapacity due to pregnancy or for prenatal care.

Chronic Conditions: 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.

Permanent or Long-term Conditions: 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.

Conditions Requiring Multiple Treatments: 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.

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

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.

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)*

PAPERWORK REDUCTION ACT NOTICE AND PUBLIC BURDEN STATEMENT

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

Madison Central School District
Superintendent Approved: 03/18/99, 04/26/11, 06/16/15, 09/18/18, 9/1/2021

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

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 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.

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)*
Inpatient Care
• An overnight stay in a hospital, hospice, or residential medical care facility. • Inpatient care includes any period of incapacity or any subsequent treatment in connection with the overnight stay.
Continuing Treatment by a Health Care Provider (any one or more of the following)
Incapacity Plus Treatment: 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: o 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, o 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.
Pregnancy: Any period of incapacity due to pregnancy or for prenatal care.
Chronic Conditions: 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.
Permanent or Long-term Conditions: 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.
Conditions Requiring Multiple Treatments: 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.

PAPERWORK REDUCTION ACT NOTICE AND PUBLIC BURDEN STATEMENT

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