

## **SICK LEAVE OF ABSENCE / NON-FMLA QUALIFIED OVERVIEW**

\*\*\*\*\*Keep this Overview for your own reference\*\*\*\*\*

PLEASE READ THOROUGHLY

This Sick Leave form is **NOT INTENDED** to be used for any leave that qualifies for or that is designated as Family Medical Leave (FMLA). This form is intended for use to substantiate the need for use of Sick Leave due to *employees own medical condition of 4 or more days* when FMLA has been exhausted or employee does not qualify for FMLA.

Employees may be granted **up to** 30 consecutive days Sick Leave for absences due to their own personal illness. Any consecutive Sick Leave absence of extending 4 days or more **MUST** submit a NON-FMLA Physician Certification packet to Leaves Management as outlined below. Any accrued sick time available will be used to compensate you while out on an **approved** sick leave. Until determination is made by Leaves Management, please follow work locations call-in procedure.

### **Sick Leave Process**

- A. **MUST** submit a Complete and Sufficient Non-FMLA Physician's Certification
  - 1) Certification for **FORESEEN** absences **must** be submitted **30 days prior to leave date.** \*
  - 2) Certification for **UNFORESEEN** absences **must** be submitted within 7 days of the fourth (4<sup>th</sup>) day of the absence occurrence.\*
- B. Signed Acknowledgement Form **MUST** be submitted **at same time as** Non-FMLA certification submitted **(SICK LEAVE WILL NOT BE PROCESSED WITHOUT RECEIPT OF ACKNOWLEDGMENT FORM)**
- C. Any leave extending beyond 30 days will require a new Updated Non-FMLA Physician Certification. The Update Certification **MUST** be received by Leaves Management 7 (seven) days prior to the end date of each Approved 30 day leave. *Failure to submit required documents will result in the concluding of your Sick Leave status.*
- D. Leaves Management may review your long term medical leave as it pertains to School Board Rule 405.03 which gives you options to resolve your work status: 1) *Apply for Service or Disability Retirement* 2) *Seek another vacant BCPSS position for which you qualify* 3) *Submit a letter of resignation.*
- E. Employee and Manager/Principal will be notified by email (unless stated otherwise on acknowledgment form) of the status of your leave within 5-10 working days of receipt.
- F. When Released to Return to Work by your Physician
  - 1) Submit return to work notification from your physician to Leaves Management
  - 2) Leaves Management will contact Mercy to schedule a RTW Exam date (*you are not permitted to return to work **for any period of time** until you and your locations have received notification that your RTW has been cleared by Mercy*)
  - 3) Employee will be notified by email and mail of your Mercy Exam date and Time
  - 4) Mercy will send Leaves Management notification of your return status
  - 5) Employee and Location/Staffing will be notified of status and a RTW date will be given (if applicable)

\*\*\*\*\*Leaves are **NOT** authorized unless approved by the Leaves Management\*\*\*\*\*

*\*Failure to receive prior approval, as described above, may result in denial of payment for the days in question and in appropriate disciplinary action.*

If at any time the requested and/or required documentation is not received timely, sufficiently or completely, Sick Leave may be denied and in addition you may not receive any type of **PAID** time off for days preceding the receipt of the required documents.

**Return COMPLETED documents to:**

**Baltimore City Public Schools / Leaves Management**  
**200 E. North Avenue, Room #110 ~ Baltimore, Maryland 21202**

**Attention: Paula Thomas**

**Phone Number: 410-396-8885    [leaves@bcps.k12.md.us](mailto:leaves@bcps.k12.md.us)    Fax Number: 410-545-0897**

Completed requests will be processed within 5-10 business days. **EMAIL IS THE PRIMARY FORM OF COMMUNICATION**, if another form of communication is necessary, please note on Acknowledgement Form. Please check your email frequently for status of your request. An approval/denial correspondence will be sent via email to you and your Principal/Supervisor. Pertinent health benefits and return to work information will be included. *Incomplete forms and/or insufficient documentation will delay leave processing.* If you have any questions, please feel free to contact me.

# BALTIMORE CITY PUBLIC SCHOOLS

This form **MUST** be signed and submitted with Request form.  
Request **WILL NOT** be processed without a signed Acknowledgement form.

## - ACKNOWLEDGEMENT -

I acknowledge responsibility for reading and complying with the Processes and Policies associated with my requested leave.

**Email is Leaves Management's primary and quickest means of communications.** All communication involving leave requests, leave determinations and designations will be sent through your **City Schools email address**.

Check which is applicable to you, *if unchecked all correspondence will be by email.*

- I **DO** have access to my city schools email and want my leaves correspondence to be sent by email.
- I **DO NOT** have access to my City Schools email and want my leaves correspondence to be sent by U.S. Mail.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Print Name – First, MI, Last

\_\_\_\_\_  
Employee ID#

\_\_\_\_\_  
Supervisor's Name

\_\_\_\_\_  
Department/School

\_\_\_\_\_  
Position

### **BTU Employee Evaluations**

In keeping with section 15.22 of the BTU contract, BTU employees who are absent more than 60 days in the school year shall receive an annual rating of "Administrative Effective/Satisfactory" on their annual evaluation with no Achievement Units (AUs). This rating can be used for certification purposes.

### **BCPS Board Rules**

Article 4 section 404.03, All absences of educational staff members shall be with loss of full pay unless otherwise provided for in these Rules, or by special action of the Board. "With loss of full pay" shall mean that the person concerned shall receive no salary for the full time included in such a leave. Such shall also include the earning of a salary from another source by the staff person on a leave without express approval of the Board and the Chief Executive Officer.

**Baltimore City Public Schools  
Division of Leaves Management  
200 E. North Avenue, Room #110  
Baltimore, Maryland 21202**

**Email: [leaves@bcps.k12.md.us](mailto:leaves@bcps.k12.md.us)**

**Attn: Ms. Paula Thomas**

**Fax: 410-545-0897**

*Falsification of any Leave of Absence documentation may lead to disciplinary action up to and including termination of employment.*

**Certification Health Care Provider Form – Non FMLA Sick Leave**

**Health Care Provider:**

**Please fill out this form COMPLETELY and SUFFICIENTLY as not to delay processing of employee’s request. When completed please return form to employee.**

Patient’s Name (please print) \_\_\_\_\_

1. Describe the medical facts which support your certification.

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2. State the most recent date/s you treated patient for this medical condition.

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3. Approximate date the **condition commenced**, and the **probable duration of the condition (and also the probable duration of the patient’s present incapacity**, if different):

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4. If the condition is a chronic condition, state whether the patient is **presently incapacitated** and the **likely duration** and **frequency of episodes** of incapacity.

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**TREATMENTS:**

5. If treatments will be required for the condition, **provide an estimate of the probable number of such treatments and actual or estimate dates of treatment.**

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6. If treatments will be provided by another provider of health services (ex: physical therapist) please state providers name and state nature of treatments or if continuing treatment by your supervision is required, provide a description of such regimen of treatment (ex: prescription drugs, physical therapy requiring special equipment):

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7. Is Employee able to perform work of any kind \_\_\_\_\_ YES \_\_\_\_\_ NO  
(Employee or Employer should supply you with information about the essential job functions).

**If YES**, please list the essential functions the employee is able to perform:

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**If NO**, is it necessary for the employee to be absent from work for treatment?

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\_\_\_\_\_  
Signature of Health Care Provider

\_\_\_\_\_  
Type of Practice

\_\_\_\_\_  
PRINT NAME of Health Care Provider

\_\_\_\_\_  
Street Address

\_\_\_\_\_  
Phone #

\_\_\_\_\_  
City/State/Zip

\_\_\_\_\_  
Date