

NEW BRUNSWICK BOARD OF EDUCATION
268 Baldwin Street, Third Floor
New Brunswick, NJ 08901
(732) 745-5300 ext. 5424 Fax (732) 846-2969

Richard Kaplan
Superintendent of Schools

Richard D. Jannarone
Business Administrator/Board Secretary

Kenya Eason
Health Benefits Coordinator
Kenya_Eason@nbps.k12.nj.us

Fitness for Duty Certification

Name _____

Location: _____

Status: Full Time _____ Part Time _____ On leave since: _____

You have my permission to contact the health care provider indicated in this certification for purposes of certification and authentication.

Signed: _____ Date: _____

(Information below to be completed by health care provider)

Effective as of _____ the above named employee is hereby certified as fit to resume work duties as follows:

- _____ Full time duties, no restrictions
- _____ Full time duties, with the following restrictions (conditions and duration)
- _____ Part time duties, no restrictions

_____ Part time duties, with the following restrictions (conditions and duration):

Intermittent duties, with the following restrictions (conditions and duration):

Additional comments, if any:

Name of health care provider: _____

Address: _____ Telephone: _____

Type of practice/specialty: _____

Signature: _____ Date: _____

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Certification of Health Care Provider

1. Employee's Name:

2. Please describe the medical condition as related to the Family & Medical Leave Act.

3. State the **date** the employee will be unable to work,

4. State the **approximate date** the employee will be able to return to work.

Signature of Health Care Provider

Type of Practice

Address

Telephone Number

Date

To be completed by the employee needing family leave to care for a family member:

State the care you will provide and an estimate of the period during which care will be provided, including a schedule if leave is to be taken intermittently or if it will be necessary for you to work less than a full schedule:

Employee Signature

Date

New Brunswick Board of Education

Request for Family and Medical Leave (FMLA)

Complete and sign the top portion of this form and submit it with the completed Certification of Health Care Provider to the Health Benefits Coordinator.

Employee Information

Name:

School:

Address:

Phone Number:

Supervisor:

Reason for FMLA Request

Employee Serious Health Condition

Child, Spouse or Parent's Serious Health Condition

Maternity, Paternity, Adoption or Foster Care

Type of Leave

Leave for a Definite Period of Time

Intermittent Leave (Please provide dates and/or anticipated duration):

Start Date of Requested Leave: _____

End Date of Requested Leave: _____

Your signature affirms that the information provided above is accurate and complete. Please be sure that the attached Certification of Health Care Provider is fully completed by your healthcare provider, if applicable.

Employee Signature and Date:

New Brunswick Board of Education

INTERNAL USE ONLY

Eligibility (circle YES or NO)

12 months service at time of request? YES NO

1250 hrs worked within a 12 month period? YES NO

Previous FMLA used during last 12 months? YES NO

If YES: _____ weeks or _____ hours

Medical Certification complete? YES NO

FMLA Approved? YES NO

Date Request Forms given to employee:

Date completed paperwork received:

Date FMLA approval/denial letter sent: _____ HBC Signature: