Human Resources Administration
270 East State Street Columbus, OH 43215
Certificated PH: (614) 365-5881
FAX: (614) 365-4044
leavesofabsence@columbus.k12.oh.us

Mission: Each student is highly educated, prepared for leadership and service, and empowered for success as a citizen in a global community.

Regular Leave of Absence

It has come to our attention, either through your request or other means, that you may need to complete ***Leave of Absence*** paperwork and that you may be eligible, if you qualify, for the Family Medical Leave Act. This paperwork is also for Worker's Comp leaves of absence.

CERTIFICATED EMPLOYEES/ADMINISTRATORS - Certificated employees or administrators who are absent for more than 10 consecutive days need to complete the ***Application for Leave*** form and submit medical documentation.
Certificated/Administrators contact: HRA phone: 365-5881/fax: 365-4044 Email: leavesofabsence@columbus.k12.oh.us

INSTRUCTIONS FOR ALL STAFF:
Listed below are attached forms that must be returned to process your leave

- ***Application for Leave*** form – which you need to complete and sign and return to Human Resources. The ***Application for Leave*** form **MUST** be signed by your Supervisor prior to your Leave of Absence unless the absence was unexpected and you are already off work.

- A ***FMLA Certification of Health Care Provider*** form **–** to be completed by your physician and all four pages returned to Human Resources (separate forms for employee and for family members).

- If not using the ***FMLA Certification of Health Care Provider*** form, please follow instructions in the medical documentation section of the information sheet. ***The Columbus City Schools reserves the right to have you examined at its' expense for the express purpose of a second opinion***

Listed below you will find attached important documents that you need to review and keep for your information
- **An Information Sheet –** this contains detailed information regarding a leave of absence, please retain this information to refer to regarding your leave.
- **Your Rights Under FMLA** document
- **If applying for Military FMLA please request the Military FMLA packet**

Failure to adhere to providing this information in a timely manner may result in your pay being stopped and/or disciplinary action up to and including termination of your employment.

Please remember that the regulations and responsibilities governing a leave of absence are your sole responsibility as stipulated in Article 702 of the Agreement between the Columbus Education Association and the Columbus Board of Education.

Sincerely,

Human Resources Administration

The Columbus City School District does not discriminate because of race, color, national origin, religion, sex or handicap with regard to admission, access, treatment or employment. This policy is applicable in all district programs and activities.

CERTIFICATED/ADMINISTRATORS APPLICATION FOR LEAVE FORM

Columbus City Schools Application for Leave

CERTIFICATED STAFF & ADMINISTRATORS

Section 701.03(B) Board/CEA Agreement
In the event the estimated duration of the absence is expected to be continuous for a period in excess of two weeks (10 days), or when an absence has been continuous for such a period, the teacher shall advise the administration of the estimated duration of disability by submitting the designated form to Human Resources by the tenth (10) day of absence and include a physician's statement. The teacher will provide the Office of Human Resources with written notice at least three school days before intending to return to the job.

Employee's Name (Please Print)		**I.D. #**	
Home Address		**Phone**	
City		**State**		**Zip**		**E-mail**	
Work Location		**Position (Teacher, etc.)**	
Employee's Signature		**Date**	
Supervisor's/Administrator's Signature		**Date**	

Signature of Supervisor/Administrator does not constitute approval of leave request)

CHECK ALL THAT APPLY: ***(See reverse side of form for explanations and documentation requirements)***

Applying for Family Medical Leave?* Yes ☐ Nc ☐

☐ Regular FML ☐ Intermittent FML ***Relationship if for family member*** ____

☐ **Sick Leave** ***(paid medical leave for***: ☐ Self ☐ Family member - ***relationship*** ____

☐ **Ill Health** ***(unpaid medical leave for***): ☐ Self ☐ Family member - ***relationship*** ____

Maternity/Paternity/Adoptive ***Select one:*** ☐ Maternity ☐ Paternity ☐ Adoptive

☐ **Assault Leave** Date of Assault ____ Incident Report Filed ☐ Yes ☐ No

☐ **Worker's compensation** Date of Injury ____ Injury Report Filed ☐ Yes ☐ No

Military Leave ☐ **Please request separate packet for FMLA Military Leave**

☐ **Exchange Teaching** ☐ **Professional Study or Travel** ☐ **Sabbatical Leave**

Special Leaves ***Please check appropriate number*** ☐ Section 702.07 or ☐ Section 702.10

☐ **Other** *(Section 702.10 o4 702.15)* **Please state reason:** ____

Paid Leave Dates

Anticipated or Actual Effective Date of Absence:	**Month**		**Day**		**Year**	

Should sick leave balance become exhausted during this medically certified period of absence you have the option of using your personal leave and vacation (if you accrue vacation), in that order? Do you wish to use your available:

(1) Personal Leave ☐Yes ☐No ***(2) Vacation (if applicable)*** ☐Yes ☐No

Current Estimated Return to Work Date:	**Month**		**Day**		**Year**	

☐ **YES,** I am releasing my position & expect my leave to extend into the subsequent school year

☐ **NO,** I do not wish to release my position

Unpaid Leave Dates

To the Superintendent of Schools:	**Today's Date**					
I Hereby Request a Leave of Absence Beginning:	**Month**		**Day**		**Year**	
And Extending Through:	**Month**		**Day**		**Year**	

NOTE: All employees who are eligible will be placed on Family Medical Leave.

LEAVE EXPLANATIONS AND DOCUMENTATION REQUIREMENTS

ASSAULT LEAVE (Section 702.01-D): A teacher may use up to forty (40) days of assault leave due to injury resulting from a physical assault on a teacher which occurs on board premises or which occurs off board premises in connection with the performance of assigned (see CEA contract for stipulations).

EXCHANGE TEACHING (Section 702.03): Request must be made two (2) months prior to the beginning of the requested leave. Request for termination of leave shall be made at least 120 days prior to the time that the teacher expects to return to duty

FMLA may be used for (1) incapacity due to pregnancy, prenatal medical care or child birth (2) to care for the employee's child after birth, or placement for adoption of foster care (3) to care for the employee's spouse, son or daughter (under the age of 18) or parent who has a serious health condition (4) for a serious health condition that makes the employee unable to perform the employee's job (5) for certain military related qualifying exigencies.

ILL HEALTH (UNPAID): (Section 702.01) Request must be accompanied by a statement from the attending physician indicating the nature of the illness and a definite recommendation that the employee be relieved of duties. Termination of leave shall be requested at least thirty (30) days before teacher expects to resume duties. A physician's statement certifying that the teacher is able to resume full duties must be submitted at least ten (10) days prior to termination of the leave.

MATERNITY/PATERNITY/ADOPTIVE (Section 702.02): A physician's statement indicating the appropriate date of delivery or an agency's statement giving the approximate date of adoption must accompany the request for leave. The requested duration of such leave shall be for the remainder of the semester in which the leave commences and not to exceed the four subsequent semesters. All such leaves must terminate at the end of a school year. Request for termination of leave shall be made at least 120 days prior to the time that the teacher expects to return to duty except when delivery occurs during such 120 days.

MILITARY LEAVE (Section 702.05): Copy of the official orders must accompany request form. Request for termination of leave should be made immediately when discharge date is known.

Please request separate packet if applying for FMLA Military Leave

OTHER (Section 702.10 OR 702.15 - CEA Contract)

PROFESSIONAL STUDY OR TRAVEL (Section 702.04 – CEA Contract): Applicant shall outline, in writing, program of study or travel to be pursued.

SABBATICAL LEAVE (*SECTION 703): Request must be in writing to the superintendent by March 1 of each year.

SICK LEAVE (PAID): (Section 701 – CEA Contract): You must be medically certified to return to work without restrictions. Notification must be submitted to Human Resources Administration at least three days prior to the anticipated date of return.

SPECIAL LEAVES. (*SECTION 702.06 AND 702.07 - CEA Contract)

FOR HUMAN RESOURCES ADMINISTRATION DEPARTMENT USE ONLY									
Leave Balances As Of:		***Per***		***S.L***		***P.L.***		***Vac.***	
☐ ***Regular FMLA***	☐ ***Intermittent FMLA***	***Through Date:***							
☐ ***Unpaid Leave***	☐ ***Yes*** ☐ ***No***	***Board Date:***							
☐ ***Approved by*** ☐ ***Denied by:***									
	Director of Human Resources Administration					**Date**			

MEDICAL DOCUMENTATION FOR THE EMPLOYEE

Please have your physician fax/return all four pages

IF NOT USING THE ATTACHED MEDICAL DOCUMENTATION FOR THE EMPLOYEE FORM, YOUR MEDICAL DOCUMENTION MUST:

- Be on the physician's letterhead
- List the beginning date of absence and estimated return to work date
- List the nature of illness or injury
- Be signed by the physician

We can only accept the original signed medical documentation or your documentation needs to be faxed directly from the physician's office to Human Resources at 614-365-4044.

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

U.S. Department of Labor
Wage and Hour Division

OMB Control Number: 1235-0003
Expires: 5/31/2018

SECTION I: For Completion by the EMPLOYER

INSTRUCTIONS to the EMPLOYER: The Family and Medical Leave Act (FMLA) provides that an employer may require an employee seeking FMLA 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. Please complete Section I before giving this form to your employee. Your response is voluntary. While you are not required to use this form, you may not ask the employee to provide more information than allowed under the FMLA regulations, 29 C.F.R. §§ 825.306-825.308. Employers must generally maintain records and documents relating to 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.

Employer name and contact: **Columbus City Schools; Certificated Phone#: 614-365-5881 / Fax#: 614-365-4044**

Employee's job title:______________________________Regular work schedule: ________________________

Employee's essential job functions: ____

____

Check if job description is attached:

SECTION II: For Completion by the EMPLOYEE

INSTRUCTIONS to the EMPLOYEE: Please complete Section II before giving this form to your medical provider. The FMLA permits an employer to require that you submit a timely, complete, and sufficient medical certification to support a request for FMLA leave due to your own serious health condition. If requested by your employer, your response is required to obtain or retain the benefit of FMLA protections. 29 U.S.C. §§ 2613, 2614(c)(3). Failure to provide a complete and sufficient medical certification may result in a denial of your FMLA request. 29 C.F.R. § 825.313. Your employer must give you at least 15 calendar days to return this form. 29 C.F.R. § 825.305(b).

Your name: ____
First   Middle   Last

SECTION III: For Completion by the HEALTH CARE PROVIDER

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

Provider's name and business address: ____

Type of practice / Medical specialty: ____

Telephone: (________)_____________________________Fax:(__________)____________________________

CONTINUED ON NEXT PAGE

PART A: MEDICAL FACTS

1. Approximate date condition commenced: ______________________________

   Probable duration of condition: ______________________________

   Mark below as applicable:

   Was the patient admitted for an overnight stay in a hospital, hospice, or residential medical care facility?
   ___No ___Yes. If so, dates of admission:

   ____

   Date(s) you treated the patient for condition:

   ____

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

   Was medication, other than over-the-counter medication, prescribed? ___No ___Yes.

   Was the patient referred to other health care provider(s) for evaluation or treatment (e.g., physical therapist)?
   ____No ___Yes. If so, state the nature of such treatments and expected duration of treatment:

   ____

2. Is the medical condition pregnancy? ___No ___Yes. If so, expected delivery date: ____________

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

   Is the employee unable to perform any of his/her job functions due to the condition: ____ No ____ Yes.

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

   ____

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

   ____

   ____

   ____

   ____

   ____

   ____

   ____

CONTINUED ON NEXT PAGE

PART B: AMOUNT OF LEAVE NEEDED

5. Will the employee be incapacitated for a single continuous period of time due to his/her medical condition, including any time for treatment and recovery? ___No ___Yes.

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

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

   If so, are the treatments or the reduced number of hours of work medically necessary?
   ___No ___Yes.

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

   ____

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

   __________ hour(s) per day;___________days per week from______________through ______________

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

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

   ____

   ____

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

Frequency :_____times per______week(s)______month(s)

Duration:______hours or____day(s) per episode

ADDITIONAL INFORMATION: IDENTIFY QUESTION NUMBER WITH YOUR ADDITIONAL ANSWER.

____

____

____

____

____

____

 CONTINUED ON NEXT PAGE

Signature of Health Care Provider

Date

PAPERWORK REDUCTION ACT NOTICE AND PUBLIC BURDEN STATEMENT

If submitted, it is mandatory for employers to retain a copy of this disclosure in their records for three years. 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 20 minutes for respondents to complete this collection of information, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. If you have any comments regarding this burden estimate or any other aspect of this collection information, including suggestions for reducing this burden, send them to the Administrator, Wage and Hour Division, U.S. Department of Labor, Room S-3502, 200 Constitution Ave., NW, Washington, DC 20210. **DO NOT SEND COMPLETED FORM TO THE DEPARTMENT OF LABOR; RETURN TO THE PATIENT.**

MEDICAL DOCUMENTATION FOR THE EMPLOYEE'S FAMILY MEMBER

Please have your physician fax/return all four pages

IF NOT USING THE ATTACHED MEDICAL DOCUMENTATION FOR THE EMPLOYEE FAMILY MEMBER FORM, YOUR MEDICAL DOCUMENTION MUST:

- Be on the physician's letterhead
- List the beginning date of absence and estimated return to work date
- List the nature of illness or injury
- Be signed by the physician

We can only accept the original signed medical documentation or your documentation needs to be faxed directly from the physician's office to Human Resources at 614-365-4044.

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

U.S. Department of Labor
Wage and Hour Division

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

OMB Control Number: 1235-0003
Expires: 5/31/2018

SECTION I: For Completion by the EMPLOYER

INSTRUCTIONS to the EMPLOYER: The Family and Medical Leave Act (FMLA) provides that an employer may require an employee seeking FMLA protections because of a need for leave to care for a covered family member with a serious health condition to submit a medical certification issued by the health care provider of the covered family member. Please complete Section I before giving this form to your employee. Your response is voluntary. While you are not required to use this form, you may not ask the employee to provide more information than allowed under the FMLA regulations, 29 C.F.R. §§ 825.306-825.308. Employers must generally maintain records and documents relating to medical certifications, recertifications, or medical histories of 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.

Employer name and contact: **Columbus City Schools, Human Resources Administration - Fax#: 614-365-4044 Certificated Phone#: 614-365-5881**

SECTION II: For Completion by the EMPLOYEE

INSTRUCTIONS to the EMPLOYEE: Please complete Section II before giving this form to your family member or his/her medical provider. The FMLA permits an employer to require that you submit a timely, complete, and sufficient medical certification to support a request for FMLA leave to care for a covered family member with a serious health condition. If requested by your employer, your response is required to obtain or retain the benefit of FMLA protections. 29 U.S.C. §§ 2613, 2614(c)(3). Failure to provide a complete and sufficient medical certification may result in a denial of your FMLA request. 29 C.F.R. § 825.313. Your employer must give you at least 15 calendar days to return this form to your employer. 29 C.F.R. § 825.305.

Your name: ____
First Middle Last

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

Relationship of family member to you: ______________________________

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

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

____

____

____

______________________________ ______________________________
Employee Signature Date

CONTINUED ON NEXT PAGE

SECTION III: For Completion by the HEALTH CARE PROVIDER

INSTRUCTIONS to the HEALTH CARE PROVIDER: The employee listed above has requested leave under the FMLA to care for your patient. Answer, fully and completely, all applicable parts below. Several questions seek a response as to the frequency or duration of a condition, treatment, etc. Your answer should be your best estimate based upon your medical knowledge, experience, and examination of the patient. Be as specific as you can; terms such as “lifetime,” “unknown,” or “indeterminate” may not be sufficient to determine FMLA coverage. Limit your responses to the condition for which the patient needs leave. Do not provide information about genetic tests, as defined in 29 C.F.R. § 1635.3(f), or genetic services, as defined in 29 C.F.R. § 1635.3(e). Page 3 provides space for additional information, should you need it. Please be sure to sign the form on the last page.

Provider’s name and business address:____

Type of practice / Medical specialty: ____

Telephone: (________)____________________________Fax:(_________)________________________________

PART A: MEDICAL FACTS

1. Approximate date condition commenced: ____

   Probable duration of condition: ____

   Was the patient admitted for an overnight stay in a hospital, hospice, or residential medical care facility?
   ___No ___Yes. If so, dates of admission: ____

   Date(s) you treated the patient for condition: ____

   Was medication, other than over-the-counter medication, prescribed? ___No ___Yes.

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

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

   ____

   ____

2. Is the medical condition pregnancy? ___No ___Yes. If so, expected delivery date: ______________________

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

____

____

____

____

CONTINUED ON NEXT PAGE

PART B: AMOUNT OF CARE NEEDED: When answering these questions, keep in mind that your patient's need for care by the employee seeking leave may include assistance with basic medical, hygienic, nutritional, safety or transportation needs, or the provision of physical or psychological care:

4. Will the patient be incapacitated for a single continuous period of time, including any time for treatment and recovery? ___No ___Yes.

   Estimate the beginning and ending dates for the period of incapacity: ___________________________________

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

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

   ____

   ____

   ____

   ____

   ____

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

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

   ____

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

   ____

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

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

   ________ hour(s) per day;_________days per week from_________________through ___________________

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

   ____

   ____

   ____

   ____

CONTINUED ON NEXT PAGE

7. Will the condition cause episodic flare-ups periodically preventing the patient from participating in normal daily activities? ____No ____Yes.

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

   Frequency:_____times per_____week(s)_____month(s)

   Duration:_____hours or____day(s) per episode

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

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

   ____

   ____

   ____

   ____

ADDITIONAL INFORMATION: IDENTIFY QUESTION NUMBER WITH YOUR ADDITIONAL ANSWER.

____

____

____

____

____

____

______________________________________ ______________________________________

Signature of Health Care Provider **Date**

PAPERWORK REDUCTION ACT NOTICE AND PUBLIC BURDEN STATEMENT

If submitted, it is mandatory for employers to retain a copy of this disclosure in their records for three years. 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 20 minutes for respondents to complete this collection of information, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. If you have any comments regarding this burden estimate or any other aspect of this collection information, including suggestions for reducing this burden, send them to the Administrator, Wage and Hour Division, U.S. Department of Labor, Room S-3502, 200 Constitution Ave., NW, Washington, DC 20210.
DO NOT SEND COMPLETED FORM TO THE DEPARTMENT OF LABOR; RETURN TO THE PATIENT.

EMPLOYEE RIGHTS AND RESPONSIBILITIES
UNDER THE FAMILY AND MEDICAL LEAVE ACT

Basic Leave Entitlement

FMLA requires covered employers to provide up to 12 weeks of unpaid, job-protected leave to eligible employees for the following reasons:

- for incapacity due to pregnancy, prenatal medical care or child birth;
- to care for the employee's child after birth, or placement for adoption or foster care;
- to care for the employee's spouse, son, daughter or parent, who has a serious health condition; or
- for a serious health condition that makes the employee unable to perform the employee's job.

Military Family Leave Entitlements

Eligible employees whose spouse, son, daughter or parent is on covered active duty or call to covered active duty status may use their 12-week leave entitlement to address certain qualifying exigencies. Qualifying exigencies may include attending certain military events, arranging for alternative childcare, addressing certain financial and legal arrangements, attending certain counseling sessions, and attending post-deployment reintegration briefings.

FMLA also includes a special leave entitlement that permits eligible employees to take up to 26 weeks of leave to care for a covered servicemember during a single 12-month period. A covered service member is: (1) a current member of the Armed Forces, including a member of the National Guard or Reserves, who is undergoing medical treatment, recuperation or therapy, is otherwise in outpatient status, or is otherwise on the temporary disability retired list, for a serious injury or illness*; or (2) a veteran who was discharged or released under conditions other than dishonorable at any time during the five-year period prior to the first date the eligible employee takes FMLA leave to care for the covered veteran, and who is undergoing medical treatment, recuperation, or therapy for a serious injury or illness.*

***The FMLA definitions of "serious injury or illness" for current service members and veterans are distinct from the FMLA definition of "serious health condition".**

Benefits and Protections

During FMLA leave, the employer must maintain the employee's health coverage under any "group health plan" on the same terms as if the employee had continued to work. Upon return from FMLA leave, most employees must be restored to their original or equivalent positions with equivalent pay, benefits, and other employment terms.

Use of FMLA leave cannot result in the loss of any employment benefit that accrued prior to the start of an employee's leave.

Eligibility Requirements

Employees are eligible if they have worked for a covered employer for at least 12 months, have 1,250 hours of service in the previous 12 months*, and if at least 50 employees are employed by the employer within 75 miles.

***Special hours of service eligibility requirements apply to airline flight crew employees.**

Definition of Serious Health Condition

A serious health condition is an illness, injury, impairment, or physical or mental condition that involves either an overnight stay in a medical care facility, or continuing treatment by a health care provider for a condition that either prevents the employee from performing the functions of the employee's job, or prevents the qualified family member from participating in school or other daily activities.

Subject to certain conditions, the continuing treatment requirement may be met by a period of incapacity of more than 3 consecutive calendar days combined with at least two visits to a health care provider or one visit and a regimen of continuing treatment, or incapacity due to pregnancy, or incapacity due to a chronic condition. Other conditions may meet the definition of continuing treatment.

Use of Leave

An employee does not need to use this leave entitlement in one block. Leave can be taken intermittently or on a reduced leave schedule when medically necessary. Employees must make reasonable efforts to schedule leave for planned medical treatment so as not to unduly disrupt the employer's operations. Leave due to qualifying exigencies may also be taken on an intermittent basis.

Substitution of Paid Leave for Unpaid Leave

Employees may choose or employers may require use of accrued paid leave while taking FMLA leave. In order to use paid leave for FMLA leave, employees must comply with the employer's normal paid leave policies.

Employee Responsibilities

Employees must provide 30 days advance notice of the need to take FMLA leave when the need is foreseeable. When 30 days notice is not possible, the employee must provide notice as soon as practicable and generally must comply with an employer's normal call-in procedures.

Employees must provide sufficient information for the employer to determine if the leave may qualify for FMLA protection and the anticipated timing and duration of the leave. Sufficient information may include that the employee is unable to perform job functions, the family member is unable to perform daily activities, the need for hospitalization or continuing treatment by a health care provider, or circumstances supporting the need for military family leave. Employees also must inform the employer if the requested leave is for a reason for which FMLA leave was previously taken or certified. Employees also may be required to provide a certification and periodic recertification supporting the need for leave.

Employer Responsibilities

Covered employers must inform employees requesting leave whether they are eligible under FMLA. If they are, the notice must specify any additional information required as well as the employees' rights and responsibilities. If they are not eligible, the employer must provide a reason for the ineligibility.

Covered employers must inform employees if leave will be designated as FMLA-protected and the amount of leave counted against the employee's leave entitlement. If the employer determines that the leave is not FMLA-protected, the employer must notify the employee.

Unlawful Acts by Employers

FMLA makes it unlawful for any employer to:

- interfere with, restrain, or deny the exercise of any right provided under FMLA; and
- discharge or discriminate against any person for opposing any practice made unlawful by FMLA or for involvement in any proceeding under or relating to FMLA.

Enforcement

An employee may file a complaint with the U.S. Department of Labor or may bring a private lawsuit against an employer.

FMLA does not affect any Federal or State law prohibiting discrimination, or supersede any State or local law or collective bargaining agreement which provides greater family or medical leave rights.

FMLA section 109 (29 U.S.C. § 2619) requires FMLA covered employers to post the text of this notice. Regulation 29 C.F.R. § 825.300(a) may require additional disclosures.

For additional information:

1-866-4US-WAGE (1-866-487-9243) TTY: 1-877-889-5627

WWW.WAGEHOUR.DOL.GOV

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

WHD Publication 1420 · Revised February 2013

Wage and Hour Division (WHD)

Family and Medical Leave Act National Defense Authorization Act for FY 2010 Amendments

(February 2010)

On October 28, 2009, the President signed into law the National Defense Authorization Act for Fiscal Year 2010 (2010 NDAA), Public Law 111-84. Section 565 of the 2010 NDAA amends the Family and Medical Leave Act (FMLA). These amendments expand the military family leave provisions added to the FMLA in 2008, which provide qualifying exigency and military caregiver leave for employees with family members who are covered military members.

The 2010 NDAA amendments to the FMLA provide that an eligible employee may take FMLA leave for any qualifying exigency arising out of the fact that the employee's spouse, son, daughter, or parent is on (or has been notified of an impending call to) "covered active duty" in the Armed Forces. "Covered active duty" for members of a **regular** component of the Armed Forces means duty during deployment of the member with the Armed Forces to a foreign country. "Covered active duty" for members of the **reserve** components of the Armed Forces (members of the U.S. National Guard and Reserves) means duty during deployment of the member with the Armed Forces to a foreign country under a call or order to active duty in a contingency operation as defined in section 101(a)(13)(B) of title 10, United States Code. (Prior to the 2010 NDAA amendments, qualifying exigency leave did not apply to employees with family members serving in a regular component of the Armed Forces and there was no requirement that members of the National Guard and Reserves be deployed with the Armed Forces to a foreign country.)

The 2010 NDAA also expands the military caregiver leave provisions of the FMLA. Military caregiver leave entitles an eligible employee who is the spouse, son, daughter, parent, or next of kin of a "covered service member" to take up to 26 workweeks of FMLA leave in a single 12-month period to care for a "covered service member" with a "serious injury or illness". Under the 2010 NDAA amendments, the definition of "covered service member" is expanded to include a **veteran** "who is undergoing medical treatment, recuperation, or therapy for a serious injury or illness" if the veteran was a member of the Armed Forces "at any time during the period of 5 years preceding the date on which the veteran undergoes that medical treatment, recuperation, or therapy." (Prior to the 2010 NDAA amendments, military caregiver leave was limited to care for current members of the Armed Forces, including regular components and National Guard and Reserves.)

In addition, the 2010 NDAA amends the FMLA's definition of a "serious injury or illness". For a current member of the Armed Forces the definition is amended to include not only a serious injury or illness that was incurred by the member in line of duty on active duty but also a serious injury or illness that "existed before the beginning of the member's active duty and was aggravated by service in line of duty on active duty in the Armed Forces" that may render the member medically unfit to perform the duties of the member's office, grade, rank, or rating. For a veteran, a serious injury or illness is defined as "a qualifying injury or illness that was incurred by the member in line of duty on active duty in the Armed Forces (or existed before the beginning of the member's active duty and was aggravated by service in line of duty on active duty in the Armed Forces) and that manifested itself before or after the member became a veteran." The 2010 NDAA directs the Secretary of Labor to define "qualifying injury or illness" of a veteran.

Read more about the FMLA at www.dol.gov/whd/fmla.

IMPORTANT

Leave of Absence Information

<u>**Certificated/Administrative employees**</u> - Certificated or administrative employees anticipating an absence or who have currently been absent for more than ten (10) consecutive days **must complete the enclosed Application for Leave form and submit the medical and/or other requested documentation to the Office of Human Resources Administration** (see the CEA Agreement, Article 701.3 (B) for more information.) If an employee's absence for a family member is three (3) or more days, but the absence does not exceed ten (10) consecutive days, the medical documentation should be forwarded to Human Resources Administration and the appropriate portion of the absence form completed. An employee will not need to complete an Application for Leave form. See the CEA contract, section 700, for the definition of an eligible family member.

<u>**Due dates for forms and documentation**</u> - Forms and documentation are due ten (10) days in advance if the leave is planned. All forms and documentation are due no later than the tenth day of absence. Failure to comply could result in a delay in loss of pay and/or disciplinary action.

MEDICAL DOCUMENTATION

<u>Acceptable Medical Documentation</u> **- Only original or medical documentation faxed directly from the physician's office to Human Resources Administration (faxed to 614-365-4044) is acceptable.**

The physician's statement must either be on the Department of Labor form provided in the packet or must:

- Be on the physician's letterhead and contain the following information:
    - List the nature of the illness/disability
    - Give the anticipated duration of the absence
    - If for intermittent leave, give the estimated need frequency of absences
    - List an estimated return to work date (without restrictions)
- Have the physician's signature (a licensed M.D., D.O., psychologist or psychiatrist)
- If leave is for an immediate family member, the physician's statement must specially state the physician's recommendation that the employee is needed to care for or assist in the care of the patient.
- Medical statements containing estimated duration of illness or estimated dates of absence due to ill health reasons will require periodic updates (approximately every 30 days) until definitive information becomes available regarding the employee's prognosis.

Forms are available online in the Human Resources section on the CCS Internet (under the Human Resources Administration section) or by contacting Human Resources Administration.

*Please read thoroughly, as failure to comply may result in loss of pay, delay in returning from leave or resuming pay, and/or disciplinary action

TYPES OF MEDICAL LEAVE

The Family Medical Leave Act (FMLA):** Leaves granted under the Family Medical Leave Act are limited to twelve (12) weeks per year and will only be considered for employees following the first year of permanent employment. (**Substitute employment is not considered permanent employment.*) The duration of the paid Family. Family Medical Leave may consist of paid leave and unpaid leave or a combination of both, dependent upon the employee's leave balances and the medical care provider's recommended period of absence. The employee must complete the application for leave form and provide medical documentation (see **Acceptable Medical Documentation** on page 1) to be considered for leave under FMLA provisions.

***Intermittent Family Medical Leave**: Intermittent leave is leave for days which are not concurrent days of absence, such as days needed for physician's appointment (for him/herself or a qualified family member) or days an employee may need to miss as related to the medical condition described in the physician's statement. A qualified family member is the employee's spouse, son or daughter (under the age of 18), or parent who has a serious health condition.

Maternity Leave: All provisions of FMLA apply to employees who take maternity leave. Physician certification is required for the medical portion of the leave in order to use paid sick leave. This would include any medically necessary absence related to the pregnancy prior to the delivery of the child. If delivery occurs during vacation, before/during/following the end of the school year, (i.e. summer months, spring or winter break), the number of weeks during those periods are all considered part of the medically certified duration of time. Days are not deducted from the employee's sick leave balance for these periods or for holidays or dates designated as "calamity days". Any time taken after an employee has been medically released by her physician cannot be deducted from sick leave; however, an employee can use other available leave balances at the end of the unpaid leave period to delay the return to work date.

Paternity Leave: As with maternity leave, all provisions of FMLA apply. In addition, use of sick leave for paternity leave is based upon physician certification of the mother and an employee's sick leave balance for medical necessity. An employee can use other available leave balances before going into an unpaid leave status for the remainder of the leave.

Certificated Adoption Leave: All provisions of FMLA apply to employees adopting a child. An employee may be paid for up to twenty (20) days of their accumulated sick leave balance at the time of the actual adoption (placement of the child/children in the employee's home). An employee may be paid for up to thirty (30) days of their accumulated sick leave if travel outside the country is necessary for the adoption. Administrators may be paid for up to ten (10) days upon placement of the child/children in the employee's home or up to thirty (30) days of accumulated sick leave if traveling outside of the country is necessary for the adoption. Documentation from the adoption agency, court, or other legal body must be submitted along with the **Application for Leave** form. An employee may qualify for an unpaid "adoption leave of absence." (see unpaid leave section of this document).

Keep in mind, however, all days of absence are deducted from the employee's leave balance for any period the employee is absent from work due to illness. If illness continues or delivery of a child occurs during break/vacation period, before/during/or following the end of the school year, i.e. summer months/spring or winter break etc., the number of weeks during these periods are considered as part of the medically certified duration of time. Sick leave, however, is not deducted for these periods nor are holidays or dates designated as "calamity" days from employees' leave balances

FAMILY MEDICAL LEAVE

Family and Medical Leave Act – Overview: The FMLA entitles eligible employees of covered employers to take unpaid, job-protected leave for specified family and medical reasons with continuation of group health insurance coverage under the same terms and conditions as if the employee had not taken leave. Eligible employees are entitled to:

Twelve work weeks of leave in a 12-month period for:

- the birth of a child and to care for the newborn child within one year of birth;
- the placement with the employee of a child for adoption or foster care and to care for the newly placed child within one year of placement;

- to care for the employee's spouse, child, or parent who has a serious health condition;
  - a serious health condition that makes the employee unable to perform the essential functions of his or her job;
- any qualifying exigency arising out of the fact that the employee's spouse, son, daughter, or parent is a covered military member on "covered active duty;" **or***
- Twenty-six workweeks of leave during a single 12-month period to care for a covered servicemember or veteran with a serious injury or illness if the eligible employee is the servicemember's spouse, son, daughter, parent, or next of kin (military caregiver leave). *

***Please request separate FMLA Military Leave Packet**

Paid Sick Leave/Unpaid Sick Leave Information

Paid Sick Leave – Extended Use of Accumulated Sick Leave: This is leave for which the employee has enough accumulated sick leave to cover the entire medically certified period of absence. When an employee's absence has extended beyond the employee's sick leave balance, that employee may opt to use part or all of their available personal leave or vacation time (if applicable). The employee would need to indicate his/her choice to use this additional time on the back (page 2) of the **Application for Leave** form. This option applies only to the medically certified portion of a leave and not beyond that point. For example, once the physician releases an employee, he/she can no longer use sick leave. An employee can use personal leave or vacation time to extend a paid leave if an employee is taking a voluntary extended unpaid leave (for example, extended maternity, paternity, or adoption leave).

Unpaid Leave – Expiration of Leave Balance or When Leave Exceeds Medical Recommendation (ill health leave): A disability period exceeding an employee's accumulated leave balances or when the employee's absence exceeds the medically certified period as stipulated by the physician (such as extended maternity/paternity/adoption leave) may result in an employee being placed on unpaid leave of absence status. Once the physician releases an employee to return to work and employee may use personal time for any additional time or it will be unpaid regardless of sick leave balances. The employee will not receive pay for a paid holiday if in an unpaid status before and/or after the paid holiday. Unpaid requested leaves of absence automatically extend through the end of the semester or the end of a school year unless permission is obtained to return earlier.

Release of Position: Certificated employees **ONLY** considering an extended leave can indicate the release/non-release of their current position while in paid leave status providing that the leave is expected to extend into the subsequent school year. Please check the appropriate box on the back (page 2) of the **Application for Leave** form.

Returning from Leave

- Notice of intent to return to work to Human Resources, 7 days in advance if in paid status, and **at least 30 days in advance if in unpaid status** ***(if Human Resources is not made aware of the employee's return, we cannot notify Payroll to restart pay or to stop deducting days from the employee's sick leave balance).***
- You do not need to be cleared through Health Services if returning from adoption or leave for a family member but will still need to give written to Human Resources prior to your return to work (see above item)
- Release from Health Services (hours/location listed below) **unless leave is for a family member, paternity or adoption,** the employee must bring a release to Health Services within 14 days of the date the physician releases the employee to return to work. ***(Should an employee return without being cleared, he/she may be sent home until the release is obtained from Health Services and delivered to Human Resources.)***

Clearance Prior to Returning to Work

All staff that have been on an extended paid or an unpaid medical leave for their own illness **must** physically deliver a release to return to work from their Health Care Provider to the Health Care Provider at Health Services. The release to return to work must be written on office letterhead or on a prescription indicating the following:

1. Date of exam from personal Health Care Provider;
2. Return to work date;
3. "No restrictions" must be written on return to work release;

The return to work release date must be within 14 days of the exam from personal Health Care Provider. **PLEASE CALL HEALTH SERVICES AT 614-365-5824 TO SCHEDULE AN APPOINTMENT WITH HEALTH SERVICES PRIOR TO RETURNING.**

Health Services Board Physician & Location
Dr. Sheryl Stephens
430 Cleveland Avenue, Suite 121A
Telephone: (614) 365-5824 Fax: (614)365-6429

Available Hours
Mondays: 1:00 to 3:00 p.m.
Tuesdays: 8:00 to 11:30 a.m.
Thursdays: 1:00 to 4:30 p.m.
Fridays: 8:00 to 11:30 a.m.

In the case of an employee taking an extended unpaid leave after being medically cleared, the employee must bring the following prior to starting the unpaid portion of the leave:

1. Release to return to work from their personal Health Care Provider to Health Services;
2. The date the employee intends to return to work.

After receiving clearance from the Board Physician, the employee will be given:

1. Two copies, (one for personal records, one for HR), of their release to return to work;
2. A pink release to return to work slip to be taken to CCS HR.

To complete the process of returning to work, the employee will be instructed to:

1. Proceed to 270 E. State Street, Human Resources;
2. Give one copy of their release to return to work and pink slip to Christina Ayers (certificated).

Additional Contact Information

LEAVE BALANCES

Information regarding leave balances/accruals must be obtained from the Payroll Office at (614) 365-6703.

SUBSTITUTE COVERAGE DURING EXTENDED ABSENCES

Employees should contact their work location or the automated Substitute Services line at (614) 365-5833 regarding substitute coverage during the extended absence. Such coverage cannot be arranged until the extended leave of absence information is submitted to the Human Resources Office.

SICK LEAVE DONATION (CATASTROPHIC SICK LEAVE)

An employee may qualify for donated sick leave due to "catastrophic" illness or injury as per the Board/CEA agreement **<u>if accumulated sick and personal leave and vacation have been exhausted</u>**. Administrators/ Certificated Employees, please contact Human Resources Administration at (614) 365-5881 for information regarding this benefit. Donated days do not change the fact that an employee will be boarded for an unpaid Leave of Absence once his/her sick leave is exhausted. The employee will still need to complete the Application for Leave and provide medical documentation. Please follow the process outlined for Returning from Unpaid Leave of Absence, on page 1 of this document. Also, please note the Release of Position section of document.

CEA Master Agreement

Contract information regarding leaves is available in the Master Agreement (Section 700) or on the CEA website, under the publications section, at: **http://www.ceaohio.org**

BENEFITS INFORMATION

<u>Unpaid Leave – Benefits continuation</u>: If placed on an unpaid medical leave of absence, please contact the Employee Benefits Office at (614) 365-6475 to ensure benefits continuation even if you are on FMLA. Once FMLA has been exhausted, the employee is responsible for paying both the employer and employee contributions while on an unpaid medical status. **Failure to make payments will result in termination of benefits coverage.**

<u>Listed below are requirements for adding your child to your benefits:</u>

- If you wish to add the new baby to your benefits, you will need to provide verification of birth documentation and complete the Benefits Enrollment/Change form within 30 days of the birth of your child. Verification consists of a certificate of live birth from the hospital followed by the birth certification and the child's social security number upon receipt. If you have questions, contact the Benefits Department at (614) 365-6475.
- Please make sure that in Human Resources Administration receives proof of live birth as well.

<u>Unpaid Leave – Benefits continuation</u>: If placed on an unpaid medical leave of absence, please contact the Employee Benefits Office at (614) 365-6475 to ensure benefits continuation even if you are on FMLA. Once FMLA has been exhausted, the employee is responsible for paying both the employer and employee contributions while on an unpaid medical status. **Failure to make payments will result in termination of benefits coverage.**

WAIVER OF BOARD OF EDUCATION SPONSORED
LIFE INSURANCE PREMIUM

All full time and part-time eligible employees have a board sponsored life insurance policy; employees also have the option to elect additional life insurance paid for through payroll deduction. Employees on a leave of absence for six months may be eligible for a waiver of premium which would keep these life insurance policies active during their leaves of absence if the employee is approved by MetLife.

Application forms for the extension of benefits can be obtained by contacting the Benefits Department at 614-365-6475 or by going to the CCS website ccsoh.us, clicking on the staff link and scrolling down to the Employee Benefits Information tab. The link to the Waiver of Premium form is available in the Additional Information section on this page.

To apply for the waiver of premium, you will need to complete a portion of the application, your physician will need to complete a portion of the application and once these are completed, you will need to bring or mail the completed forms to CCS Human Resources for a member of the Benefits team to complete the employer portion and submit the application to MetLife for their review. You will be notified by MetLife if you have been approved.

For additional information regarding the Waiver of Premium

Contact MetLife at 1-800-300-4296

WORKERS COMPENSATION INFORMATION

Workers Compensation: Information regarding benefits such as insurance, worker's compensation, etc. may be obtained by calling the Benefits Office at (614) 365-6475.

Absence Due To Work-Related Injury: If a Work-Related Injury claim is identified as "lost time" (more than 7 days) with the Bureau of Worker's Compensation (BWC), and the employee needs to take time off as a result of the initial injury, the employee will need to:

 Complete the **"Leave of Absence"** form and provide medical documentation to certify his/her absence from work.
 Identify pay status – The employee has two options:
1. Go unpaid and receive compensation reimbursement from the BWC directly
OR
2. Remain in paid status, using his/her available leave balances (personal, vacation or sick.)

NOTE: The BWC does not pay an employee for lost wages while he/she is using his/her sick time. However, CCS does offer a **"Sick Leave Buy-Back Program"** as a form of a wage agreement. The "Sick Leave Buy-Back Program" can be used by an employee to be reimbursed for SOME of the sick leave he/she used while out on a Worker's Compensation-approved leave. Intent to be reimbursed for this time MUST BE IDENTIFIED AT THE BEGINNING of the leave. **Failure to complete this process within 30 days of the date of injury will result in the employee being ineligible for this reimbursement.** Contact the Benefits Department at (614) 365-6475 for information.

Workers' Compensation runs concurrent with FMLA

Bureau of Workers' Compensation

Notice to BWC of the Injured Worker and Employer Agreement and Authorization to Send Injured Worker's Check(s) to the Employer

Instructions

- This form is for injured workers who may qualify for temporary total disability and who have entered into an agreement with their employer to reimburse the employer for wages or sick leave paid during the disability.
- Fax this completed form to 1-866-336-8352, or send it to your local BWC customer service office.

Injured worker's name	Claim number	Date of injury

Agreement/Authorization

The injured worker and employer must sign, date and submit this form to BWC within 30 calendar days of the beginning date of payment from the employer to the injured worker of wages, sick leave or advancement. The beginning date is the day the first payment was issued to the injured worker, not the beginning date of the period of time that is paid.

The injured worker and employer are hereby giving BWC notice that you both agree the employer has paid or agrees to pay wages, sick leave or an advancement of wages to the above-named injured worker.

The first payment was made on ___/___/____ at a rate of $________________ per week.

The employer has paid or agrees to pay from ____/____/____ to ____/____/____. This time period cannot exceed 12 weeks unless special circumstances exist, and BWC has approved it. If the time period noted changes, the employer must notify BWC. If BWC does not receive notice of the change, BWC will not send the injured worker's compensation payments in care of the employer.

By signing, the injured worker authorizes BWC to send his/her check in care of the employer for any temporary total compensation the injured worker would have been eligible to receive during the period of this agreement. The injured worker must personally endorse the warrants.

I certify the information on this form is true and correct to the best of my knowledge. I understand that any person who knowingly makes a false statement, misrepresentation, concealment of fact or any other act of fraud to obtain benefits and/or compensation as provided by BWC or self-insuring employers, or who knowingly accepts compensation to which that person is not entitled, is subject to criminal prosecution and may, under appropriate criminal provisions, be punished by a fine or imprisonment or both.

Injured worker's signature	Date signed
X	
Employer's signature and title	Date signed
X	

Contact Us... Anytime, Anywhere

No-cost, confidential solutions to life's challenges.

Confidential Emotional Support

Our highly trained clinicians will listen to your concerns and help you or your family members with any issues, including:

- Anxiety, depression, stress
- Grief, loss and life adjustments
- Relationship/marital conflicts

Work-Life Solutions

Our specialists provide qualified referrals and resources for just about anything on your to-do list, such as:

- Finding child and elder care
- Hiring movers or home repair contractors
- Planning events, locating pet care

Legal Guidance

Talk to our attorneys for practical assistance with your most pressing legal issues, including:

- Divorce, adoption, family law, wills, trusts and more

Need representation? Get a free 30-minute consultation and a 25% reduction in fees.

Financial Resources

Our financial experts can assist with a wide range of issues. Talk to us about:

- Retirement planning, taxes
- Relocation, mortgages, insurance
- Budgeting, debt, bankruptcy and more

Online Support

GuidanceResources® Online is your 24/7 link to vital information, tools and support. Log on for:

- Articles, podcasts, videos, slideshows
- On-demand trainings
- "Ask the Expert" personal responses to your questions

Copyright © 2018 ComPsych Corporation. All rights reserved. To view the ComPsych HIPAA privacy notice, please go to www.guidanceresources.com/privacy. ComPsych complies with applicable federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability or sex.

Your ComPsych® GuidanceResources® program offers someone to talk to and resources to consult whenever and wherever you need them.

Call: 800.774.6420
TDD: 800.697.0353

Your toll-free number gives you direct, 24/7 access to a GuidanceConsultant℠, who will answer your questions and, if needed, refer you to a counselor or other resources.

Online: guidanceresources.com
App: GuidanceResources® Now
Web ID: CCS

Log on today to connect directly with a GuidanceConsultant about your issue or to consult articles, podcasts, videos and other helpful tools.

24/7 Support, Resources & Information

COLUMBUS CITY SCHOOLS

Contact Your GuidanceResources® Program

Call: 800.774.6420
TDD: 800.697.0353
Online: guidanceresources.com
App: GuidanceResources® Now
Web ID: CCS

Copyright © 2018 ComPsych Corporation. All rights reserved.