Office of Human Resources
145 Spring Valley Road
Paramus, NJ 07652-5390

Carla Alvarez, Director
(201) 261-7800, ext. 3005
calvarez@paramusschools.org
Fax (201)576-9180

To: Paramus School District Employees

From: Human Resources

Date: July 31, 2020

Re: COVID-19 Related Temporary & Permanent Leave & Accommodation Requests and Process Guidelines for Requests

Dear Staff:

As the anticipated opening of the new school year approaches, you may have questions or concerns about your own and/or a family member's health, and/or childcare. We understand and appreciate that each of your situations are different and unique.

The attached guidance and forms detail some of the options available to you and the process to follow for each scenario. As a request is submitted, we set up meetings with you individually to determine the right course of action with you on an individual basis because each of your situations will be unique.

Action is only required by those seeking an accommodation or leave of absence. We request you notify us as soon as practicable so that we may also plan for the best educational environment for our students.

If you do not submit one of these requests we will look forward to seeing you in September.

Thank you in advance for your prompt response and patience as we work through these processes together.

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Process Guidelines For COVID-19 Related Temporary and Permanent Leave and Accommodations Requests

NOTICE TO ALL EMPLOYEES

1. **Disability or CDC High Risk Category Accommodation Request (for Employee's condition only)**
   a. Employee to complete Disability Accommodation Request form and **submit with Physician's Certification**.
   b. If approved via the Interactive Process with employee, employee will be granted an accommodation. ***Employers are not required to provide a reasonable accommodation if doing so would cause an *undue hardship which is defined as* an accommodation that would be unduly costly, extensive, disruptive or would fundamentally alter the nature or operation of the business
   c. If not approved due to it causing an undue hardship on the employer, employee may be eligible for sick leave or possibly FMLA entitlement (see # 2 below) depending on the seriousness of the health condition.

2. **Leave Request (for Employee's own health condition including advisement by healthcare provider or public health authority to quarantine)**
   a. Employee completes COVID Related Leave Form and applicable Federal form and medical certification. Medical certifications are REQUIRED for all Medical Leave Requests.
   b. If approved, the employee is eligible for up to 80 hours of paid leave under the Federal Emergency Paid Sick Leave Act or FEPSL (prorated for PT employees) in ADDITION to regular 12 weeks of FMLA/NJFLA (running consecutively). The FEPSL is payable from day one of employment at the employee's full wage subject to a maximum of $511/day and a total maximum of $5110. An employee can opt to use existing sick leave before or after this FEPSL pay period. Benefits are retained during the leave periods with normal contributions.

3. **Leave Requests (for Childcare)**
   a. Employee completes COVID Related Leave.
   b. Employee is eligible for Federal Emergency Paid Sick Leave (FEPSL) and FMLA Emergency Childcare Leave under FFCRA. NJ Family Leave is not available unless the leave begins within one year of the date the child is born or placed with the employee. Otherwise NJFLA for care of the child is only for the child's serious health condition. FMLA and NJFLA run consecutively. FEPSL is in addition to the other leaves. The FEPSL is payable from day one at 2/3 of the employee's wages with a maximum of

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$200/day and a total maximum of $2000. The Emergency Childcare Leave benefit under FMLA and FFRCA does not extend the maximum 12 weeks and it requires an employee to have been employed for at least 30 calendar days however it does require the employer to pay the employee. The payment under ECL is 2/3 of the employees' wages with a maximum of $200/day or $10,000 maximum. The first two weeks are unpaid under ECL, followed by up to 10 weeks paid. Benefits are retained during the Leave periods with normal contributions. Employee could apply directly for New Jersey Family Leave Insurance (NJFLI) benefits. See scenario chart. See Spanish scenario chart. See additional language scenario charts.

4. **Leave Requests (For Care of a Covered Family Member with a Serious Health Condition)**
   a. Employee completes COVID Related Leave Form and applicable Federal form and medical certification REQUIRED for all Medical Leave conditions.
   b. If approved, the employee is eligible for up to 80 hours of paid leave under the Federal Emergency Paid Sick Leave Act (prorated for PT employees) in ADDITION to the regular 12 weeks of FMLA/NJFLA running concurrently. Note: eligible employees are those that have worked in the prior 12 months/1250 hours of employment. The FEPSL is payable from day one at the full wage with a maximum of $511/day and a total maximum of $5110. Benefits are retained during the leave periods with normal contributions. Employee could apply directly for New Jersey Family Leave (NJFLI) benefits. See scenario chart. See Spanish scenario chart. See additional languages scenario charts.

5. **Leave Requests (For Care of a Loved one for coronavirus quarantine, illness or symptoms)**
   a. Employee completes COVID Related Leave Form and applicable Federal form and **Medical certification or Public Health Authority advisement required for this leave request**.
   b. Employee is eligible for Emergency Paid Sick Leave for up to 80 hours. The payment under ECL is 2/3 of the employees' wages with a maximum of $200/day or $2,000 maximum available from day one of employment. Standard unpaid FMLA rules apply for the remainder of the 10 weeks provided the employee is eligible for those weeks. Benefits are retained during the Leave periods with normal contributions.
   c. Note: NJFLA does not currently extend to self-quarantining unless advised by a healthcare provider or public health authority.

6. **Self-Quarantining**
   Currently (7/30/20) state guidelines call for advisements to self-quarantine for various scenarios relating to out of state travel, potential exposures to those having traveled out of state, etc. Since these guidelines are advisories and not orders there are currently no

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enforcement provisions in place. We are recommending that staff follow the advisories, have a COVID test upon return before coming back to work, taking leave to quarantine for the required period, and/or discussing the possibility of remote work depending on your position. https://covid19.nj.gov/faqs/nj-information/travel-information/which-states-are-on-the-travel-advisory-list-are-there-travel-restrictions-to-or-from-new-jersey

Note: The Families First Coronavirus Response Act provides the Emergency Childcare Leave and Federal Emergency Paid Sick Leave benefits only through December 31, 2020.

7. **Resignation or Retirement**
   If you make the very personal decision not to return to work at all we request that you notify the district in writing as soon as possible. In addition, we are here to discuss what the financial and benefit impacts of that decision may be regarding pension and health benefits if you are considering these as options.

PARAMUS PUBLIC SCHOOL DISTRICT
COVID-19 RELATED REQUEST FOR LEAVE OF ABSENCE

Name_____ Date_____

Position _____ Building _____
[Grade(s) and Subject(s)]

Best contact phone #: _____ Personal email address: _____

Reason for Leave request:

☐ I am seeking a leave for my own health condition including advisement by my healthcare provider or pursuant to a federal, state, or local public health authority order to quarantine or I am experiencing symptoms of COVID-19 and am seeking a medical diagnosis. Complete and submit the following form. https://www.dol.gov/sites/dolgov/files/WHD/legacy/files/WH-380-E.pdf

☐ I am seeking a leave due to childcare needs during the COVID-19 pandemic. I am seeking the following schedule for childcare purposes: (Please provide name of School or Daycare that has closed or is running remotely for each child).

Child's Full Name	Child's Age	School/Childcare Name

☐ I am seeking a leave to care for a loved one who is in coronavirus quarantine, is coronavirus positive or symptomatic. Complete and submit the following form. https://www.dol.gov/sites/dolgov/files/WHD/legacy/files/WH-380-F.pdf

☐ I am seeking a leave to self-quarantine for 14 days commencing _____ through _____ due to travel outside the State of New Jersey or other reasons NOT certified by healthcare providers or public health authorities. https://covid19.nj.gov/faqs/nj-information/travel-information/which-states-are-on-the-travel-advisory-list-are-there-travel-restrictions-to-or-from-new-jersey

☐ I am seeking an intermittent leave for the period _____to_____.
If intermittent or reduced-leave schedule is being requested, please explain why it is needed and the proposed leave schedule:

PARAMUS PUBLIC SCHOOL DISTRICT
COVID-19 RELATED REQUEST FOR LEAVE OF ABSENCE

**************************COMPLETED WITH HUMAN RESOURCES*************************

Current # of available sick days: _____ # of sick days requested: _____

Do you wish to use your personal or emergency days during this leave, if applicable? Yes ☐ No ☐

Will you be requesting to use Federal Family Medical Leave (FMLA) via the Families First Coronavirus Relief Act (FFRCA)? Yes ☐ No ☐

How many days are you requesting to use under FMLA/FFRCA? (up to 60 work days) _____

Will you be requesting to use Federal Emergency Paid Sick Leave (FEPSL)? Yes ☐ No ☐

How many hours are you requesting to use under FEPSL? _____
(FT-up to 2 weeks/80 hours for 10 days; PT-average hours per week for 10 days)

Will you be requesting to use NJ Family Medical Leave (NJFLA), if applicable? Yes ☐ No ☐

How many days are you requesting to use under FMLA/FFRCA? (up to 60 work days) _____

If your leave must be extended for any reason do you wish to use additional sick time? Yes ☐ No ☐
If so, up to how many days? _____

If your leave must be extended for any reason do you wish to use additional time under FMLA/NJFLA/FEPSL?

FMLA/FFRCA: _____ days

NJFLA: _____ days

FEPSL: _____ hours

Will you be applying for NJ Family Leave Insurance? Yes ☐ No ☐

I, the undersigned, certify that all information above is true to the best of my knowledge at the time of this request and agree to the above requested leave status. I also understand my financial obligation toward my health benefits remains in effect during my leave and if I do not return from my leave in which FMLA or NJFLA was used, I will be responsible for the full health benefit premium paid by Fort Lee Public Schools on my behalf during my leave.

Signature of Employee: _____ Date: _____

**************************COMPLETED WITH HUMAN RESOURCES **************************

PARAMUS PUBLIC SCHOOL DISTRICT
COVID-19 RELATED REQUEST FOR LEAVE OF ABSENCE

********** FOR HUMAN RESOURCES USE**********

Date received: _____

Approval Date: _____

Board Action: _____

PAID/UNPAID TIME OFF CALCULATION WITH DATES

Employee's PTO

_____

FEPSL (up to 80 hours Medical – Full Pay max of $511 per day/COVID Childcare – 2/3 max of $200 per day)

_____

_____

FMLA/FFCRA (12 weeks – 2 unpaid – 10 paid 2/3 max of $200 per day)

_____

_____

NJFLA (12 weeks unpaid in applicable – not available for COVID childcare unless within one year of birth or for child's own serious medical condition)

_____

_____

Other Unpaid Leave

_____

_____

Benefits Calculations

_____

_____

Additional Notes/Information

_____

_____

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Employee Request for Reasonable Accommodation
Americans with Disabilities Act (ADA)

INSTRUCTIONS FOR EMPLOYEE:

Step 1: Fill the Employee section on the attached page. Sign and date where indicated.

Step 2: Take both forms (**"Employee" and "Interactive Process Certification and Questionnaire"**), **along with a copy of your job description supplied by the Human Resources Department**, to the appropriate medical provider. Ask the medical provider to examine the job description and fill out the Interactive Process Certification and Questionnaire.

Step 3: You, or your physician, should return the completed forms to the Human Resources Department (by personal delivery, mail, fax, or electronic transmission).

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Fax: 201-576-9180

Step 4: Paramus Public Schools - Human Resources Department will contact you for an appointment to begin the interactive process of evaluating your request.

NOTES TO EMPLOYEE:

Paramus Public Schools will make every effort to reasonably accommodate employees in accordance with the Americans with Disabilities Act of 1990 (ADA), as amended.

The ADA defines disability as a mental or physical impairment that substantially limits a major life activity, and generally requires accommodation for employees who are qualified to perform their essential job duties and have a disability or have a record of having a disability.
PLEASE NOTE ALL ACCOMODATION REQUESTS REQUIRE MEDICAL CERTIFICATIONS.

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EMPLOYEE

Printed Name: _____ Last 4 digits of SSN: _____

Job Title: _____ Location: _____

Home Address: _____

Best Contact Phone #: _____ Personal Email: _____

☐ I am seeking accommodations under the ADA because I am at high risk for contracting the COVID-19 virus under the CDC's pandemic guidelines.
https://www.cdc.gov/coronavirus/2019-ncov/need-extra-precautions/people-at-increased-risk.html

☐ I am seeking accommodations under the ADA for non-COVID-19 related reasons.
https://adata.org/factsheet/reasonable-accommodations-workplace

1. What if any, job function are you having difficulty performing?

2. How does your disability affect the essential functions of your job?

3. Do you have a suggestion on an accommodation? Yes ☐ No ☐

If yes, please describe how it will assist you:

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4. I am seeking an accommodation for the period _____ to _____.

☐ I have attached a completed Physician's Certification form.

☐ The Physician's Certification is being sent under separate cover.

☐ I have not yet seen my physician. My appointment is _____.

NOTE TO EMPLOYEE:
Paramus Public Schools' Human Resources staff may need to contact your healthcare provider directly.

By signing the **Authorization for the Use and Disclosure of Protected Health Information Form** on the next page, you give Paramus Public Schools' Human Resources staff authorization to contact your medical provider regarding medical information needed to process this request for ADA reasonable accommodation.

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Authorization for the Use and Disclosure of Protected Health Information

In connection with my request for accommodation from my employer under the American with Disabilities Act (ADA), I hereby authorize the use and disclosure of my protected health information as described below to the Paramus Board of Education's ("Board") Medical Inspector for the purpose of evaluating and substantiating my request for accommodations from my employer.

I, _____ hereby authorize,

Dr. _____ to disclose, make

available, and furnish the following to the Paramus School District's physician, Dr. Michael Meese.

Contact Information:
Dr. Michael Meese
17 Elm Ave.
Hackensack, NJ 07601
Phone: (201) 968-0508
FAX: (201) 968-0509
Email: ***Please include all**: drmeese@optonline.net
office@drmeese.net
judy@drmeese.com
adrienne@drmeese.com

Any and all information (including computer-generated information), documents, records, reports, notes, correspondence, patient charts, prescriptions, x-rays, and test results relating to the condition that led to my request for leave from employment, along with the approximate date of examination, treatment, consultation or admission to hospital that led to my request for sick leave from my employment and the accommodations that I am presently seeking from my employer.

I understand that I may revoke this authorization at any time by notifying the organization providing the information in writing with a copy of this written revocation to the Board. However, the revocation will not be valid if the Board has taken action in reliance on this authorization. Further, revoking this authorization may impact my ability to be granted accommodations.

_____ _____
Employee's Name (Please Print) Date

_____ _____
Employee Signature: Date

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INSTRUCTIONS FOR MEDICAL PROVIDER:

Review the duties and requirements on the employee's job description which is attached. If not attached please contact Paramus Public Schools Human Resources Department at 201-261-7800 Ext. 3002 or 3048 and ask for a copy of the applicable job description to be faxed to you.

Fully complete the **Interactive Process Certification and Questionnaire** beginning on the next page and return it to the employee or directly to Paramus Public Schools Human Resource Services Department at the location noted in Step 3.

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ADA – ACCOMODATION REQUEST
INTERACTIVE PROCESS CERTIFICATION AND QUESTIONNAIRE
[TO BE COMPLETED BY HEALTHCARE OR MEDICAL PROVIDER[1]]

To: Healthcare or Medical Provider
From: Paramus Public Schools' Human Resources Department

Please feel free to add attachments if you need more room to give your complete opinion. Thank you for your cooperation which will help Paramus Public Schools process this request.

PLEASE DO NOT TAKE INTO CONSIDERATION ANY AMELIORATIVE EFFECTS OF MITIGATING MEASURES; USE OF ASSISTIVE TECHNOLOGY, AUXILIARY AIDS OR SERVICES; REASONABLE ACCOMMODATIONS; OR LEARNED BEHAVIORAL OR ADAPTIVE NEUROLOGICAL MODIFICATIONS UNLESS ASKED TO PROVIDE SUCH INFORMATION. Mitigating measures include medications, medical supplies, equipment, or appliances, low-vision devices (excluding ordinary eyeglasses or contacts), prosthetics including limbs and devices, hearing aids and cochlear implants or other implantable hearing devices, insulin, mobility devices, and oxygen therapy equipment/supplies.

Employee's Name: _____

Employee's Job Title: _____

Medical Provider's printed name and address: _____

_____

_____

Medical Provider's Telephone Number: _____ Fax Number: _____

Medical Provider's Specialty: _____

[1] For purposes of this request, a healthcare or medical provider is defined as someone authorized to practice and provide services, and qualified to provide certification of physical or mental impairment, and who is performing within the scope of their practice as defined under applicable state law.

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Please supply the information requested below, as fully as possible.

1. Does employee have an impairment/condition? Yes ☐ No ☐ Physical ☐ Mental ☐

   If so does this impairment/condition cause the employee to be particularly vulnerable to COVID-19? Yes ☐ No ☐

If Yes to this is COVID Related - Skip to Questions 11 to 13.

2. If so, clearly identify the impairment/condition (You can attach additional pages):

3. How long do you expect the impairment to last?

4) In your opinion, does the impairment substantially limit any major life activity?
   Yes ☐ No ☐

   If yes, state the major life activities that are limited:

5) For each major life activity that is limited by the impairment, describe how the employee is restricted as to the condition, manner, or duration under which that activity can be performed, as compared to the way an average person in the general population can perform that activity?

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6) Did the employee provide you with a copy of the applicable job description?
Yes ☐ No ☐

7) Did the employee provide you with a recitation of the essential functions of their job?
Yes ☐ No ☐

If yes, please provide the information given to you by the employee as to the essential functions of their job.

8) Is employee able to perform all essential job functions and physical requirements?
Yes ☐ No ☐

If not, specify any essential job functions/requirements that cannot be performed, and explain why not.

9) Describe any reasonable accommodations you recommend to enable the employee to perform their essential job duties.

10) In your opinion, would performing any of employee's essential job duties pose a direct health or safety threat to the employee, co-workers, students, members of the general public, etc.? Yes ☐ No ☐

If yes, please state:

a) Which job duties would result in such a threat?

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b) What is the specific threat?

c) Are there any reasonable accommodations that would eliminate the threat, or reduce it to an acceptable level? Yes ☐ No ☐

If yes, please describe the accommodations:

11. Medical Condition(s) that causes Employee to be particularly vulnerable to COVID-19:

12. For each condition, please explain **with a reasonable degree of medical certainty** *(use multiple forms, as needed)*:

a. Approximate date when condition commenced.

b. The anticipated duration of the condition (if unknown, please advise the condition will persist through June 30, 2021).

c. How condition causes the Employee to be particularly vulnerable to COVID-19.

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d. Whether there are workplace accommodations that would decrease the risk for the Employee to perform the essential functions of his/her position (please refer to the Employee's job description).

e. For any workplace accommodations you identified above, please explain how they would prevent the Employee from being particularly vulnerable to COVID-19.

f. Under what circumstances the employee would no longer be deemed particularly vulnerable to COVID-19?

13. Next treatment/examination date of Employee. _____

_____ _____

Medical Provider's Signature and Title: Date