



DENTON INDEPENDENT SCHOOL DISTRICT
Insurance Department
P. O. Box 1951
Denton, TX 76202
940-369-0028
940-369-4980 - fax

Temporary Disability Leave (TDL)

General Information

Each full-time employee shall be given a leave of absence for temporary disability at any time the employee's health condition interferes with the performance of regular duties. The maximum length of this leave is 180 calendar days. For purposes of temporary disability leave, pregnancy is considered a temporary disability. TDL can be requested only for the employee's illness, and is for new employees who do not qualify for Family Medical Leave (FML) first or have exhausted FML and still need to be absent because the employee has not been medically released to return to work. TDL should be requested only if the employee will be out more than five (5) consecutive workdays. The contract or employment of the employee may not be terminated while the employee is on an approved leave of absence for temporary disability.

Employee Request for Leave

A request for a leave of absence for temporary disability must be made to the Superintendent, via the Insurance Department. The request must:

- Be accompanied by a physician's medical certification confirming inability to work;
- State the date requested by the employee for the leave to begin; and
- State the probable date of return as certified by the physician.

*Employees must request approval for temporary disability leave by submitting a letter to the Denton ISD Insurance Office. The letter should be addressed to Jamie Wilson, Ed.D. Superintendent, and must include reason(s) for the leave and the date requested by the employee for the leave to begin. The leave request must be accompanied by a physician's medical certification confirming the employee's inability to work and estimating a probable date of return. *If temporary disability leave is approved, the length of leave is for no longer than 180 calendar days.* If an employee is placed on temporary disability leave involuntarily, he or she may protest the action by presenting evidence of fitness to work.*

Requesting TDL

To request TDL, complete and return the following 4 documents to Phyllis Klein, Denton ISD Insurance Office:

1. Letter addressed to the superintendent
2. Temporary Disability Employee Request for Leave Form
3. Medical Certification form
4. Use of Leave Designation Form

They can be faxed to 940-369-4980 or emailed to pklein@dentonisd.org

Medical Certification

~Must be completed by a licensed healthcare provider~

Health care provider is defined as a doctor of medicine who is authorized to practice medicine or surgery. A health care provider does include others who are authorized to practice (e.g. podiatrists, clinical psychologists, optometrists, chiropractors, and Christian Science Practitioners). Board policy DEC (LEGAL) fully lists all acceptable practitioners or you may contact the Insurance Department for further assistance.

When the leave is foreseeable and at least 30 days' notice has been provided, the employee should provide the medical certification before the leave begins. When this is not possible, the employee must provide the requested certification to the employer within the time frame requested by the employer (which must allow at least **15 calendar days after the employer's request**), unless it is not practicable under the particular circumstances to do so despite the employee's diligent, good faith efforts.

Return to Work

When an employee is ready to return to work, it is the employee's responsibility to deliver a health care provider release (fitness for duty report) to the DISD Insurance Office. This must be an original form signed by the doctor stating the return to work date and if there are any restrictions. Phyllis Klein or an Insurance professional will review and determine if employee is eligible to return to work. If it is determined you can return to work, the employee will be emailed a **Return to Work Notice**. The notice will also be emailed to the employee's Supervisor. All employees must report to the Insurance office and receive a **Return to Work Notice** prior to returning to his/her campus or department.

Placement

An employee returning to active duty after a leave of absence for temporary disability is entitled to an assignment at the school/department where the employee formerly worked, subject to the availability of an appropriate position. In any event, the employee shall be placed on active duty no later than the beginning of the next school year. A principal at another campus voluntarily may approve the appointment of an employee who wishes to return from leave of absence. However, if no other principal approves the assignment by the beginning of the next school year, the District must place the employee at the school at which the employee formerly worked or was assigned

RETURN TO:

Phyllis Klein
Denton ISD
Insurance Office
P.O. Box 1951
Denton, Texas 76202
Fax: 940-369-4980

For questions on Temporary Disability Leave and Insurance contact Phyllis Klein at 940-369-0028.

For payroll questions contact Pam Hammons, Payroll Supervisor, at 940-369-0020.



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Request for Temporary Disability Leave

Must be submitted at least 30 days, if possible, prior to the date the requested leave is to begin.

Last Name		First Name		Employee ID #	
Address			City	State	Zip
Home Phone	Home Email Address		Date of Hire		
Job Title			Home Campus/Department		

Check the type of leave you are requesting:

☐ **Serious illness/injury that affects:**

Requested # of weeks: _____ or # of days: _____ (180 calendar days maximum)

Date leave to start: _____ Anticipated date of return: _____

(Employees seeking leave due to a serious illness/injury must provide a medical certification within 15 days of approval)

☐ **Birth or Adoption of Child:**

Expected date of birth: _____

Requested # of weeks: _____ (Between 1 and 12 work weeks) or # of days: _____ (60 work days maximum)

Date leave to start: _____ Anticipated date of return: _____

I understand that the leave I am requesting is an unpaid leave except where use of sick leave, personal days, vacation days and compensatory time are required. Any days taken where leave is unavailable are taken without pay. I understand that the District requires use of all accumulated state sick leave, local sick leave, state personal leave, vacation and compensatory time during leave. I understand that the leave begins on the date specified and shall run concurrently with Family Medical Leave (FML) and Temporary Disability Leave (TDL) as it applies. I understand that while I am on TDL, the District will not continue to pay its contribution toward my medical insurance premium. I understand that I will not be permitted to resume my position with the District until I provide a doctor's medical release, specifying the date that I am released to return to work. I have read and understand ***District Policy DEC (LOCAL) and CRD (LOCAL)***. I attest that the above information is true and correct. I have read and understand the terms and conditions of my leave.

Employee's Signature _____ Date _____

Insurance Department Use Only

Signature: _____ Date Appvd: _____



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USE of LEAVE AUTHORIZATION

Employee Name _____ Employee ID # _____
(Please Print)

Job Title _____ Campus _____ Department _____

Employee Signature _____ Date Signed _____

Check Appropriate Box Indicating Type of Leave Requested:

☐ Family Medical Leave ☐ Workers' Compensation ☐ Temporary Disability Leave

Select the order in which earned leave will be taken during your absence. You may also decide on the number of days/hours per category to be charged to your leave balances.

Failure to designate the order will result in your leave being charged as follows:

- 1) Local leave;
- 2) State sick leave (accumulated before the 1995-96 school year)
- 3) State personal leave;
- 4) Other (vacation, compensatory, etc)

Use of sick leave bank days shall be permitted only after all available state and local leave has been exhausted.

Please circle the order you would like to use your leave and fill in the number of days/hours per category.

1 2 3 I choose to use _____ days/hours. of Local leave.

1 2 3 I choose to use _____ days/hours. of State sick leave (accumulated before the 1995-96 school year).

1 2 3 I choose to use _____ days/hours. of State leave.

1 2 3 I choose to use _____ days/hours. of Other (vacation, compensatory, etc)

**FAILURE TO RETURN THIS FORM WILL RESULT IN LEAVE CHARGED AS STATED ABOVE.
YOUR SELECTIONS ARE FINAL.**

FORM MUST BE RETURNED TO THE INSURANCE DEPARTMENT



DENTON INDEPENDENT SCHOOL DISTRICT

Insurance Department

P. O. Box 1951

Denton, TX 76202

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MEDICAL CERTIFICATION FOR TEMPORARY DISABILITY LEAVE (TDL)

This form must be completed

Employer Name and Contact: Denton Independent School District
PO Box 1951
Denton, TX 76202
ATTN: Insurance Department.

Employee's Job Title: _____ Regular Work Schedule _____

Employee's Essential Job Functions: _____

Completion by the EMPLOYEE

Your Name: _____
First Middle Last

Completion by the HEALTH CARE PROVIDER

Provider's Name and Business Address: _____

Type of Practice / Medical Specialty: _____

Telephone: () _____ Fax: () _____

1. Approximate date condition commenced: _____

Probable duration of condition: _____

2. Is the medical condition pregnancy? ☐ Yes ☐ No If yes, expected delivery date: _____

Is the employee unable to perform any of his/her job functions due to the condition? ☐ Yes ☐ No

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

3. 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? ☐ Yes ☐ No

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

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):

Signature of Health Care Provider

Date