Print Form

REQUEST FOR FAMILY MEDICAL LEAVE

Employee Request for Family & Medical Leave (FMLA) and/or Oregon Family Leave (OFLA)

Where the need for leave may be anticipated, written request for family and medical leave must be made, if practical, at least 30 days prior to the date requested leave is to begin. Failure to request leave in a timely manner could result in either the leave being postponed or the amount of the leave available reduced up to three weeks.

This is to advise you that you have a right under the FMLA/OFLA for up to 12 weeks of unpaid/paid leave in a 12-month period for the reasons listed below.

Section I: To be completed by Employee

Today's Date _____ Requested Date of Leave _____ Expected Return Date _____

Employee Name _____

Home Phone Number _____ Social Security Number _____

Hire Date _____ Length of Service _____

Position _____ Building Location _____

Status: ☐ Full Time ☐ Part Time ☐ Temporary

I request family or medical leave for one or more of the following reasons:

☐ Birth of Child
Estimated Date of Delivery _____

☐ Placement for Adoption or Foster Care
Estimated Date of Placement _____

☐ Family Member's ***Serious Health Condition****
Specific Relationship _____

☐ My Own ***Serious Health Condition****

*See separate sheet for explanation of ***Serious Health Condition***. Must submit a ***Physician or Practitioner Certification*** with 15 days from date of request for any ***Serious Health Condition*** for self or family member.

Type of family or medical leave requested:

☐ Consecutive Days (up to 12 weeks)
From _____ Through _____

☐ Intermittent Leave
Expected Days/Weeks/Months on Leave _____

☐ Reduced Leave Schedule
Specify Change in Schedule _____

Have you taken a family leave in the past 12 months? ☐ Yes ☐ No If yes, how many workdays? _____

Section I: To be completed by Human Resources

Today's Date _____ Date Request Received _____

This is to Inform you that:

☐ You are **NOT** eligible for Leave under the FMLA/OFLA plan for the reason(s) listed below:

_____

_____

☐ You **ARE** eligible for Leave under the FMLA/OFLA plan.
The requested leave ☐ will ☐ will not be counted against your annual FMLA entitlement

☐ Medical Certification is required. Certification must be received by _____

(must be at least 15 calendar days after you are notified of this requirement) or we may delay the commencement of your leave until the certification is submitted.

☐ Supporting documentation is required to verify adoption or foster care placement of a child.

☐ You will be required to submit the Physician or Practitioner Certification form prior to your return to work.

You are required to use accrued paid time for FMLA/OFLA leave in the order shown below:

1. Sick Leave
2. Personal Leave
3. Vacation Leave (if applicable)
4. Other

I understand that the district requires me to use any accrued sick leave, personal leave days, vacation leave, or other paid time in the order specified by the district before taking leave without pay for the family medical leave period.

If my request for a leave is approved it is my understanding that without an authorized extension when the need for an extension could be anticipated, I must report to duty on the first workday following the date my leave is scheduled to end. I understand that failure to do so will constitute unequivocal notice of my intent not to return to work and the district may terminate my employment.

I understand that if indicated above, I must provide medical certification within 15 days of receiving the notice.

I authorize the district to deduct from my paychecks any employee contributions for health insurance premiums (medical/dental/vision) while I am on paid leave and any employee contributions still due from any unpaid leave after my leave is completed, consistent with state and/or federal law.

I have read all of the above. I understand all the terms and conditions of this leave.

_____ _____

Employee's Signature Date

_____ _____

Human Resources' Signature Date