APPLICATION FOR FAMILY AND MEDICAL LEAVE

Oregon Family Medical Leave (OFLA) and/or Federal Family and Medical Leave Act (FMLA)

EMPLOYEE INFORMATION

Employee Group: ☐ Administrator ☐ Licensed ☐ Classified ☐ Confidential

Name: _____ Building Location: _____

Dates of Anticipated Leave: from _____/_____/_____ through _____/_____/_____ ☐ New Application ☐ Revised _____ Date

REASON FOR LEAVE

For requests due to a serious health condition, including pregnancy, written certification from a health care provider must be provided to the District using the *Certification of Health Care Provider* form. Select your type of leave below.

☐ **Parental Leave**. To care for an employee's newborn, newly adopted or newly placed foster child under 18 years of age or for a newly adopted or newly placed foster child 18 years of age or older who is incapable of self care because of a physical or mental impairment. This leave must be taken in one uninterrupted period (no intermittent or reduced work schedule); however, exceptions apply for adoption of a child or placement of a foster child. Two employed family members may not take concurrent parental leave.

Care of a newborn child? ☐ Yes ☐ No Anticipated birth of child: ____/____/____
Adoption of a child? ☐ Yes ☐ No Anticipated date of adoption: ____/____/____
Placement of a foster child? ☐ Yes ☐ No Anticipated date of placement: ____/____/____

☐ **Employee's Serious Health Condition** *(Certification of Health Care Provider required)*.

☐ **Family Member's Serious Health Condition** *(Certification of Health Care Provider required)*. Please select qualifying family member: ☐spouse*, ☐child (biological, adopted, foster, stepchild, legal ward), ☐grandchild, ☐parent (biological, custodial, noncustodial, adoptive, foster, stepparent), ☐grandparent, ☐parent-in-law, ☐parent of employee's registered domestic partner, ☐person with whom employee is/was in a relationship of in loco parentis.

☐ **Pregnancy Disability**. Taken by female employee's for disability related to pregnancy or childbirth, occurring before or after the birth of the child, or for prenatal care. *(Certification of Health Care Provider required)*.

☐ **Sick Child Leave**. To care for an employee's child suffering from an illness or injury that requires home care but is not a serious health condition. The child must be under the age of 18 or an adult dependent child substantially limited by a physical or mental impairment as defined by ORS 659A.100(2)(d). Routine appointments do not qualify.

If your leave is for your child, is anyone else available to care for him/her? ☐ Yes ☐ No

☐ **Military Family Leave**. Taken for qualifying exigency while employee's ☐spouse, ☐son, ☐daughter, or ☐parent is on covered active duty or called to covered active duty during the deployment of the member with the Armed Forces; or your spouse or domestic partner has been notified of impending call to active duty, has been ordered to active duty, or has been deployed or on leave from deployment. Please check one of the following:

☐ A copy of the covered military member's active duty orders is attached.

☐ Other documentation from the military certifying that the covered military member is on active duty (or has been notified of impending call to active duty) in support of a contingency operation is attached.

☐ **Injured Service Member Leave**. Taken to allow employee to care for covered service member who is the employee's ☐spouse, ☐son, ☐ daughter, ☐parent or ☐next of kin (nearest blood relative) who has been injured in the line of duty.

☐ **Death of a Family Member Leave**. Taken to attend the funeral of the family member, make arrangements necessitated by the death of the family member or grieve the death of the family member (must be completed within 60 days of the date on which the eligible employee receives notice of death of family member). Please select qualifying family member: ☐spouse*, ☐child (biological, adopted, foster, stepchild, legal ward), ☐grandchild, ☐parent (biological, custodial, noncustodial, adoptive, foster, stepparent), ☐grandparent, ☐parent-in-law, ☐parent of employee's registered domestic partner, ☐person with whom employee is/was in a relationship of in loco parentis.

*"Spouse" means individuals in a marriage, including "common law" marriage and same-sex marriage. For OFLA, spouse also includes same-sex individuals with a Certificate of Registered Domestic Partnership.

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ADDITIONAL INFORMATION

Do you have a spouse that is employed by the Seaside School District and who is also planning to take time off for the same leave as listed above? ☐ Yes ☐ No If yes, from ____/____/____ through ____/____/____

Will it be necessary for you to take leave only intermittently or to work on a less than regular work schedule as a result of the leave (a health care provider must authorize a reduced or intermittent work schedule)? ☐ Yes (indicate Reduced or Intermittent) ☐ No

☐ Reduced schedule starting ___/___/___ Please describe schedule: _____

☐ Intermittent leave starting ___/___/___ Please describe schedule: _____

I understand that my leave approval may be delayed until the *Certification of Health Care Provider* form is returned. I understand that in the case of my own serious health condition, I may not be able to return to work until I provide a release from my health care provider, which may include a fitness-for-duty certification that addresses my ability to perform the essential duties of my job. I understand that the District does require that employees use appropriate accrued leave before a period of unpaid leave as applicable to my employee group. I agree that while I am on leave, I will continue to pay my share of insurance premiums, if applicable, unless I elect to discontinue coverage. Finally, I understand that if I do not return to work on the date indicated above (or another date as specified by me and agreed to by the District), my employment may be terminated by the District as of the date my leave expires.

I authorize the District to deduct from my paychecks and employee contributions for health insurance premiums, life insurance or long-term disability insurance which remain unpaid after my leave, consistent with state and/or federal law.

It is understood by both the employee and the employer that if approved, this requested leave application does qualify for OFLA/FMLA. Accordingly, that this approved application is notification that the leave will be counted against the employee's annual family and medical leave entitlement and that the District uses a fixed leave year calendar that begins July 1st. Please refer to OAR 839-009-0200 to 0320 and/or Seaside School District policy GCBDA/GDBDA regarding your legal family medical leave rights.

I have been provided a copy of the District's family and medical leave policy and a copy of my rights and responsibilities under the Family Medical Leave Act.

_____ _____

Employee's Signature **Date Signed**

DISTRICT APPROVAL (TO BE COMPLETED BY DISTRICT OFFICE ONLY)

☐ Approved Leave Type: ☐ FMLA only ☐ OFLA only ☐ FMLA/OFLA Concurrent

☐ Conditionally Approved - pending receipt of: _____

☐ Denied, Reason: _____

Maximum allowed leave: _____

Designation and order of approved leave: _____

_____

For Employee's Serious Health Condition: A medical release will be required for absences of more than three consecutive days or when there is a significant change to the original leave schedule, and may include a fitness-for-duty certification which addresses the employees ability to perform the essential duties of the job.

_____ _____

Superintendent's Signature **Date Signed**