Federal Family and Medical Leave/State Family and Medical Leave

Effective Date

The Family and Medical Leave Act (FMLA) generally took effect as federal law August 5, 1993. The Oregon Family Leave Act (OFLA) became effective as state law September 9, 1995. The Military Family Leave as part of the National Defense Authorization Act became effective January 28,2008, which gave leave to military families for specific circumstances.

Coverage

Federal law covers public agencies, including districts. In order for school employees to be eligible, however, they must be employed at a work site with 50 or more employees within 75 miles of the employee's work site for each working day during each of the 20 or more calendar workweeks in the year in which the leave is taken or in the preceding calendar year. State law covers districts that employ 25 or more part-time or full-time employees for each working day during 20 or more calendar workweeks in the calendar year in which the leave is to be taken, or in the calendar year immediately preceding the year in which the leave is to be taken.

Eligibility

Federal law applies to employees who have worked for the district for at least 12 months and for at least 1250 hours during the year preceding the start of the leave. State law generally applies to employees who work an average of 25 hours or more per week for the district during the 180 days or more immediately prior to the first day of the start of the requested leave. For parental leave purposes, an employee becomes eligible upon completing at least 180 days immediately preceding the date. on which the parental leave begins. There is no minimum average number of hours worked per week when determining employee eligibility for parental leave.

In determining that an employee has been employed for the preceding 180 calendar days, the employer must count the number of days an employee is maintained on the payroll, including all time paid or unpaid. If an employee continues to be employed by a successor in interest to the original employer, the number of days worked are counted as continuous employment by a single employer.

In determining 25 hours average workweek, the employer must count the actual hours worked using guidelines set out pursuant to the Fair Labor Standards Act.

Request for Family and Medical Leave

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

PLEASE PRINT

Where the need for the leave may be anticipated, written request for family and medical leave must be made, if practical, at least 30 days prior to the date the 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 leave available reduced up to three weeks.

Name _____ Effective Date of the Leave _____

Department _____ Title _____

Status: □ Full-time □ Part-time □ Temporary

Hire Date _____ Length of Service _____

I request family or medical leave for one or more of the following reasons:[1]

_____ 1. Because of the birth of my child and in order to care for him or her.

Expected date of birth _____ Actual date of birth _____

Leave to start _____ Expected return date _____

_____ 2. Because of the placement of a child with me for adoption or foster care. Age of child _____

Date of placement _____

Leave to start _____ Expected return date _____

_____ 3. In order to care for a family member[2] with a serious health condition.

Leave to start _____ Expected return date _____

Please check one: ____ Spouse ____ Same-sex domestic partner (OFLA leave only) ____ Child ____ Parent

____ Parent-in-law, parent of employee's same-sex domestic partner, custodial parent, noncustodial parent,

adoptive parent, foster parent ____ Grandparent or Grandchild (OFLA leave only.)

Please state name and address of relation:

_____

[1]A physician's certification may be required to support a request for family and medical leave. In addition, a fitness for duty certification may be required before reinstatement following the leave.

[2]"Family member" means the spouse, same-sex domestic partner, custodial parent, noncustodial parent, adoptive parent, foster parent, biological parent, grandparent, parent-in-law, parent of employee's same-sex domestic partner or a person with whom the employee is or was in a relationship of "in loco parentis." It also includes the biological, adopted, grandchild or foster child or stepchild of an employee, child of same-sex domestic partner or a child with whom the employee is or was in a relationship of "in loco parentis."

Name _____ Address _____

Describe serious health condition _____

_____ 4. For a serious health condition which prevents me from performing my job functions. Describe

_____

_____

Leave to start _____ Expected return date _____

Regarding 3. or 4. above, request intermittent (reduced workday hours) or reduced leave (fewer workdays each workweek) schedule or alternate duty (if applicable, subject to employer's approval). Please describe schedule of when you anticipate you will be unavailable to work:

_____

_____

_____ 5. In order to care for a child with a condition requiring home care which does not meet the definition of serious health condition and is not life threatening or terminal (OFLA leave only). ___ Yes ___ No

Have you taken a family leave in the past 12 months? ___ Yes ___ No

If yes, how many workdays? _____

_____ 6. A qualifying exigency arising from an employee's spouse, son, daughter, or parent who is on active duty, or has been notified of an impending call to active duty status, in support of a contingency operation.

_____ 7. To care for the serious illness or injury of a spouse, son, daughter, parent, or next of kin[3] who is a covered service member.

I understand that the district requires me to use any accrued sick leave, vacation, personal leave days or other paid time established by Board policy(ies) and/or collective bargaining agreement in the order specified by the district, and before taking leave without pay, for the family and 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 authorize the district to deduct from my paychecks any 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.

I have been provided a copy of the district's family and medical leave policy with this family and medical leave request form.

Signature of Employee: _____ Date: _____

[3] "'Next of kin" means the nearest blood relative of the eligible employee.

Sample Letter to Employee - FMLA/OFLA Leave

The following is a sample cover letter to an employee notifying the employee that the employer is treating a request for leave as a request for FMLA and/or OFLA leave (either paid or unpaid) that will reduce the employee's FMLA and/or OFLA leave entitlement. This letter should be mailed to the employee within two working days after the employee's request for the leave along with the FMLA/OFLA notice form.

Dear Employee:

On (date) you advised the district that you were requesting a leave under the Family and Medical Leave Act (FMLA) and/or Oregon Family Leave Act (OFLA). Under our policy, leaves of absence that qualify for family and medical leave under federal law (FMLA) run concurrently with other types of leave such as sick leave, vacation leave, short-term disability leave and leave for a workers' compensation injury or illness. Leaves of absence that qualify for family and medical leave under state law (OFLA) can run concurrently with other types of leave such as sick leave, vacation leave, short-term disability leave but cannot run concurrently with leave for workers' compensatory injury or illness.

We understand the purpose of your requested leave qualifies as family medical leave under state and/or federal law. Accordingly, this letter is to notify you that the leave will be counted against your annual family and medical leave entitlement. Also attached is a form entitled FMLA/OFLA Notice to Employee which contains other information for you regarding federal and state family medical leave rights.

Sincerely,

Superintendent
Enclosure (FMLAlOFLA Notice to Employee form)

FMLA/OFLA Notice to Employee

DATE: _____

TO: _____
(Employee's name)

FROM: _____
(Name of appropriate employer representative)

SUBJECT: Request for FMLA and/or OFLA Leave

On ___(date)___ you notified us of your need to take family/medical leave due to:

1. _____ The birth of your child, or the placement of a child with you for adoption or foster care;

2. _____ A serious health condition that makes you unable to perform the essential functions of your job;

3. _____ A serious health condition of your 0 spouse, 0 same-sex domestic partner (OFLA leave only), 0 child (including the biological, grandchild, adopted or foster child or stepchild of an employee, child of same-sex domestic partner or a child with whom the employee is or was in a relationship of "in loco parentis"), 0 parent (biological parent of an employee or an individual who stood "in loco parentis" to an employee when the employee was a child), 0 grandparent, 0 parent-in-law, parent of employee's same-sex domestic partner, custodial parent, noncustodial parent, adoptive parent, foster parent (OFLA leave only) for which you are needed to provide care;

4. _____ An illness or injury to your child which requires home care but is not a serious health condition (OFLA leave only).

5. _____ A qualifying exigency arising from a spouse, son, daughter, or parent on active duty, or has been notified of an impending call to active duty status, in support of a contingency operation.

6. _____ A serious illness or injury of a covered service member who is your spouse, son, daughter, parent or next of kin.

You notified us that you need this leave beginning on _____(Date)_____ and that you expect leave to continue until on or about ___(Date)___.

Except as explained below, you have a right under the FMLA and/or OFLA for up to 12 workweeks of unpaid leave in a 12-month period for the reasons listed above. FMLA leave and OFLA leave generally run concurrently. In order to care for an injured service member, you are entitled to up to 26 weeks of leave in a singe 12-month period to care for a qualifying service member.

Also, your health benefits under FMLA must be maintained during any period of unpaid leave under the same conditions as if you continued to work. You must be reinstated to the same or in some cases, under state or federal law, to an equivalent job with the same pay, benefits and terms and conditions of employment on your return from leave. The district is not required to maintain benefits during OFLA unless provided otherwise by Board policy or collective bargaining agreement; however, all such benefits will be restored in full upon your return to the district.

If you do not return to work following FMLA and/or OFLA leave for a reason other than: (1) the continuation, recurrence or onset of a serious health condition which would entitle you to FMLA and/or OFLA; or (2) other circumstances beyond your control, you may be required to reimburse the district for health insurance premiums paid on your behalf during your FMLA/OFLA leave.

This is to inform you that *(check appropriate boxes, explain where indicated)*:

1. You are ☐ eligible ☐ not eligible for leave under the ☐ FMLA, ☐ OFLA or ☐ both.

2. The requested leave ☐ will ☐ will not be counted against your annual ☐ FMLA leave entitlement, ☐ OFLA, ☐ both.

3. You ☐ will ☐ will not be required to furnish medical certification of a serious health condition. If required, you must furnish certification by (date) (must be at least 15 days after you are notified of this requirement).

4. You may elect to substitute accrued paid leave for unpaid FMLA leave. We ☐ will ☐ will not require that you substitute accrued paid leave for unpaid FMLA and/or OFLA leave. If paid leave will be used the following conditions will apply: (Explain)

5a. If you normally pay a portion of the premiums for your health insurance, these payments will continue during the period of FMLA leave. Arrangements for payment have been discussed with you and it is agreed that you will make premium payments as follows: (Set forth dates, e.g., the 10th of each month, or pay periods, etc. that specifically cover the agreement with the employee.)

5b. The district is not required to maintain benefits while an employee is on OFLA leave unless otherwise provided for by Board policy and/or collective bargaining agreements; however, all benefits must be restored in full upon the employee's return to work.

5c. If the district pays any part of your share of health or other insurance benefits while on OFLA or FMLA leave the district may deduct up to 10 percent of your gross pay each pay period after your return to work until the amount is repaid (OFLA leave only).

5d. You have a minimum 30-day (or, indicate longer period, if applicable) grace period in which to make premium payments. If payment is not timely made, your group health insurance may be cancelled, provided we notify you in writing at least 15 days before the date that your health coverage will lapse, or, at our option, we may pay your share of the premiums during FMLA leave or, OFLA leave as provided by Board policy and/or collective bargaining agreement, and recover these payments from you upon your return to work. We ☐ will ☐ will not pay your share of health insurance premiums while you are on FMLA and/or OFLA leave.

5e. We ☐ will ☐ will not do the same with other benefits (e.g., life insurance, disability insurance, etc.) while you are on FMLA and/or OFLA leave. If we do pay your premiums for other benefits, when you return from leave you ☐ will ☐ will not be expected to reimburse us for the payments made on your behalf.

5f. Except as noted above, in the event you do not return to work for the district after your FMLA and/or, OFLA leave and the district has paid your share of benefit premiums, you ☐ will ☐ will not be responsible for reimbursing the district the amount paid on your behalf, with the exceptions noted in Section 104 (c)(2)(B) of the FMLA.

6. You ☐ will ☐ will not be required to present a fitness-for-duty certificate prior to being restored to employment following leave for your own serious health condition. If such certification is required but not received, your return to work may be delayed until the certification is provided.

7a. You ☐ are ☐ are not a "key employee" as described in Section 825.218 of the FMLA regulations. If you are a "key employee," restoration to employment may be denied following FMLA leave on the grounds that such restoration will cause substantial and grievous economic injury to us. (FMLA leave only.)

7b. We ☐ have ☐ have not determined that restoring you to employment at the conclusion of FMLA leave will cause substantial and grievous economic harm to us. (FMLA leave only.) (Explain (a) and/or (b) below.)

8. While on FMLA and/or OFLA leave, you ☐ will ☐ will not be required to furnish us with periodic reports every (indicate interval of periodic reports, as appropriate for the particular leave situation) of your status and intent to return to work. If the circumstances of your leave change and you are able to return to work earlier than the date indicated on this form, you ☐ will ☐ will not be required to notify us at least two workdays prior to the date you intend to report for work.

9. You ☐ will ☐ will not be required to furnish recertification relating to a serious health condition. (FMLA leave only.) (Explain below, if necessary, including the interval between certifications as prescribed in Section 825.308 of the FMLA regulations.)

Medical Certification Form
(To be completed by health-care provider)

Certification of Health-care Provider
(Family and Medical Leave Act of 1993)

1. Employee's Name: _____

2. Patient's Name (if different from employee): _____

3. The attached sheet describes what is meant by a "serious health condition" or a "serious illness or injury of a covered service member" under the Family and Medical Leave Act. Does the patient's condition[4] qualify under any of the categories described? If so, please check the applicable category.

   (1) _____ (2) _____ (3) _____ (4) _____ (5) _____ (6) _____

   None of the above _____

4. Describe the medical facts which support your certification, including a brief statement as to how the medical facts meet the criteria of one of these categories:

5a. State the approximate date the condition commenced and the probable duration of the condition (and also the probable duration of the patient's present incapacity[5] if different):

5b. Will it be necessary for the employee to work only intermittently or to work on a less than full schedule as a result of the condition (including treatment described in Item 6 below):

   If yes, give the probable duration:

5c. If the condition is a chronic condition (condition #4) or pregnancy, state whether the patient is presently incapacitated and the likely duration and frequency of episodes of incapacity:

6a. If additional treatments will be required for the condition, provide an estimate of the probable number of such treatments.

   If the patient will be absent from work or other daily activities because of a treatment on an intermittent or part-time basis, also provide an estimate of the probable number and interval between such treatments, actual or estimated dates of treatment if known and period required for recovery if any:

[4] Here and elsewhere on this form, the information sought relates only to the condition for which the employee is taking FMLA leave.

[5] "Incapacity," for purposes of FMLA, is defined to mean inability to work, attend school or perform other regular daily activities due to the serious health condition, treatment therefor or recovery therefrom.

6b. If any of these treatments will be provided by another provider of health services (e.g., physical therapist), please state the nature of the treatments.

6c. If a regimen of continuing treatment by the patient is required under your supervision, provide a general description of such regimen (e.g., prescription drugs, physical therapy requiring special equipment):

7a. If medical leave is required for the employee's absence from work because of the employee's own condition (including absences due to pregnancy or a chronic condition), is the employee unable to perform work of any kind? _____

7b. If able to perform some work, is the employee unable to perform anyone or more of the essential functions of the employee's job (the employee or the employer should supply you with information about the essential job functions)?_____ If yes, please list the essential functions the employee is unable to perform:

7c. If neither 7a. nor 7b. applies, is it necessary for the employee to be absent from work for treatment? _____

8a. If leave is required to care for a family member of the employee with a serious health condition, does the patient require assistance for basic medical or personal needs or safety, or for transportation? _____

8b. If no, would the employee's presence to provide psychological comfort be beneficial to the patient or assist in the patient's recovery? _____

8c. If the patient will need care only intermittently or on a part-time basis, please indicate the probable duration of this need:

9. Was the serious illness or injury sustained in the line of duty, while on active duty, that may render the person medically unfit to perform the duties of the person's office, grade, rank, or rating?

_____ _____

(Signature of Health-care Provider) (Type of Practice)

_____ _____

(Address) (Telephone Number)

To be completed by the employee needing family leave to care for a family member:

State the care you will provide and an estimate of the period during which care will be provided, including a schedule if leave is to be taken intermittently or if it will be necessary for you to work less than a full schedule:

(Employee Signature) (Date)

A "serious health condition" means an illness, injury, impairment or physical or mental condition of an employee or family member that involves one of the following:

1. Hospital Care

   Inpatient care (i.e., an overnight stay) in a hospital, hospice or residential medical care facility, including any period of incapacity or subsequent treatment in connection with or consequent to such inpatient care.

2. Absence Plus Treatment

   A period of incapacity of more than three consecutive calendar days (including any subsequent treatment or period of incapacity relating to the same condition) that also involves:

   a. Treatment[6] two or more times by a health-care provider, by a nurse or physician's assistant under direct supervision of a health-care provider or by a provider of health-care services (e.g., physical therapist) under orders of, or on referral by, a health-care provider; or
   b. Treatment by a health-care provider on at least one occasion which results in a regimen of continuing treatment[7] under the supervision of the health-care provider.

3. Pregnancy

   Any period of incapacity due to pregnancy or for prenatal care.

[6]Treatment includes examinations to determine if a serious health condition exists and evaluations of the condition. Treatment does not include routine physical examinations, eye examinations or dental examinations.

[7]A regimen of continuing treatment includes, for example, a course of prescription medication (e.g., an antibiotic) or therapy requiring special equipment to resolve or alleviate the health condition. A regimen of treatment does not include the taking of over-the-counter medications such as aspirin, antihistamines or salves; or bed-rest, drinking fluids, exercise and other similar activities that can be initiated without a visit to a health-care provider. An exception to this definition of regimen could occur when an employee suffers from a minor illness generally treated with over-the-counter medication, bed rest and intake of fluids so long as the employee is incapacitated for more than three days and is under continuing treatment by a health-care provider for the specific ailment.

4. Chronic Conditions Requiring Treatments

   A chronic condition which:

   a. Requires periodic visits for treatment by a health-care provider or by a nurse or physician's assistant under direct supervision of a health-care provider;
   b. Continues over an extended period of time (including recurring episodes of a single underlying condition); and
   c. May cause episodic rather than a continuing period of incapacity (e.g., asthma, diabetes, epilepsy, etc.).

5. Permanent/Long-term Conditions Requiring Supervision

   A period of incapacity which is permanent or long-term due to a condition for which treatment may not be effective. The employee or family member must be under the continuing supervision of, but need not be receiving active treatment by, a health-care provider. Examples include Alzheimer's, a severe stroke or the terminal stages of a disease.

6. Multiple Treatments (Nonchronic Conditions)

   Any period of absence to receive multiple treatments (including any period of recovery therefrom) by a health-care provider or by a provider of health-care services under orders of, or on referral by, a health-care provider, either for restorative surgery after an accident or other injury, or for a condition that would likely result in a period of incapacity of more than three consecutive calendar days in the absence of medical intervention or treatment, such as cancer (chemotherapy, radiation, etc.), severe arthritis (physical therapy), kidney disease (dialysis).

A "serious illness or injury of a covered service member" means an injury or illness incurred by the member in the line of duty, while 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.