

Central School District 13J

Code: **GCBDA/GDBDA-AR(2)**
Revised/Reviewed: 11/03/08; 6/06/11; 1/13/13;
4/07/14; 9/14/15; 1/11/16

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 member² with a serious health condition.

Leave to start _____ Expected return date _____
Please check one: Spouse³ Child⁴ Parent Individual who was in *loco parentis* when the employee

¹A 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 registered 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 or the parents of registered domestic partner or a child with whom the employee is or was in a relationship of "in loco parentis."

³"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.

⁴For FMLA, the age of the son or daughter at the onset of disability is not relevant in determining a parent's entitlement to FMLA leave.

was a child Parent-in-law or the parent of the employee's registered domestic partner (OFLA leave only)
 Custodial parent Noncustodial parent Adoptive parent Foster parent Grandparent (OFLA leave only)
 Grandchild (OFLA leave only).

Please state name and address of relation:

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: approval.

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 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 kin⁵ who is a covered service member.

I understand that I may use any accrued paid leave, including personal and sick leave or accrued vacation leave 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 and a copy of my rights and responsibilities under the Family Medical Leave Act.

Signature of Employee: _____ Date: _____

⁵"Next of kin" means the nearest blood relative of the eligible employee.