

Douglas Education Service District

Code: **GCBDA/GDBDA-AR(2)**
Revised/Reviewed: 4/16/15; 3/28/16

Request for Family and Medical Leave Confidential

Employee - Please read, complete this form, and return to HR as soon as possible: 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 by up to three weeks.

Name _____ Anticipated Dates of Leave _____

Department _____ Title _____

District _____ Licensed Classified Administrator Confidential

Full-time Part-time Regularly scheduled hours per week _____ Days: M T W U F (circle days scheduled to work)

Have you taken a family leave in the past 12 months? Yes No
If yes, how many work days? _____ Reason for leave _____

Do you have a spouse employed by the same district who is requesting time off for the same purpose? Yes No

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/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 Parent-in-law Custodial Parent Noncustodial Parent
 Parent of employee's registered domestic partner (OFLA only) Adoptive Parent Foster Parent
 Grandparent or grandchild (OFLA leave only)

Please state name and address of relation:

Name _____ Address _____

Does the condition render the family member unable to perform daily activities? Yes No

Please explain: _____

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, stepparent 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." Additionally, when defining "family member" under OFLA (but not FMLA leave), this definition includes a grandparent, grandchild, parent-in-law or parent of registered domestic partner.

³"Spouse" means individuals in a marriage, including "common law" marriage or same sex marriage. For OFLA, spouse also includes same-sex individuals with 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.

4. For a serious heal 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) Age of Child** _____

6. A qualifying exigency arising from an employee' s spouse, son, daughter, or parent who is a covered service member as defined in DESD BOARD POLICY 2115 & 2115 (AR) (or employee's District Policy), or leave for the spouse of a military personnel per each deployment of the spouse when the spouse has either been notified of an impending call to active duty, has been ordered to active duty, or has been deployed or on leave from deployment. **(CERTIFICATION FORM AR(3)(C) required)**

7. To care for a spouse, son, daughter, parent, or next of kin⁵ who is a covered service member with a serious illness or injury incurred in the line of duty or active duty in the armed forces. Has leave been taken for the same service member and the same injury?
 Yes No **(CERTIFICATION FORM AR(3)(D) required)**
 If yes, when was the leave taken and for how many work days? _____

8. To grieve the loss of a family member (Bereavement Leave/OFLA only). Two weeks in a 60 day period after being notified of the family member's death allowed as protected leave. _____

Supervisor Name: _____ Is supervisor informed of request6 for OFLA/FMLA Yes No

I understand that my employer requires me to use any accrued sick leave, vacation, personal leave days or other paid time established by Board policies and/ or collective bargaining agreement in the order specified by my employer, 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 my employer may terminate my employment. **A FITNESS FOR DUTY CERTIFICATION may be REQUIRED** prior to returning to work. I authorize Douglas ESD 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 my rights and responsibilities under the Family Medical Leave.

Signature of Employee: _____ Date: _____

**Return this form to: Douglas ESD, Human Resources, Attn: Connie Rosas
 1871 NE Stephens, Roseburg, OR 97470
 or via email: Crosas@desd.k12.or.us
 Questions? Phone: 541-440-4785**

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