

Dufur School District 29

Code: GCBDA/GDBDA-AR(2)
Revised/Reviewed: 12/02/13

Request for Family, Military and Medical Leave Employee Request for Oregon Family Leave Act (OFLA)

PLEASE PRINT

Where the need for the leave may be anticipated, written request for OFLA leave must be made, if practical, at least 30 days prior to the date the requested leave is to begin. Failure to provide timely notice could result in the district reducing the available OFLA leave by 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 OFLA 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: Spouse Same-gender domestic partner Parent Child Parent-in-law
 Parent of employee's same-gender domestic partner Custodial parent Noncustodial parent
 Adoptive parent Foster parent Grandparent Grandchild

Please state name and address of relation:

Name _____ Address _____

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

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

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 OFLA leave in the past 12 months? Yes No
- If yes, how many workdays? _____

- _____ 6. Leave for the spouse of a military personnel when they have been notified of an impending call to active duty, ordered to active duty, or has been deployed or on leave from deployment.

- _____ 7. The death of a family 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 OFLA 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 law.

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

Signature of Employee: _____	Date: _____
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