Helix School District 1R

Code: **GCBDA/GDBDA-AR(4)**
Revised/Reviewed: 5/14/08; 1/08/09; 6/10/09; 2/10/10; 9/18/13; 12/11/13; 9/09/15; 12/16/15; 6/14/17

OFLA Eligibility Notice to Employee

Date: _____

To: _____
(Employee's name)

From: _____
(Name of appropriate employer representative)

SUBJECT: Request for OFLA Leave

On _____ (date) you notified us of your need to take Oregon Family Leave Act (OFLA) 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 ☐ spouse[1], ☐ child (including the biological, grandchild, adopted, foster child or stepchild of an employee or a child with whom the employee is or was in a relationship of "in loco parentis"), ☐ parent (biological parent of an employee or an individual who stood "in loco parentis" to an employee when the employee was a child), ☐ grandparent, ☐ parent-in-law or parent of registered domestic partner, ☐ custodial parent, ☐ stepparent ☐ noncustodial parent, ☐ adoptive parent, ☐ foster parent, 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.

5. _____ Your spouse has been notified of an impending call to active duty, has been ordered to active duty, or has been deployed or on leave from deployment.

6. _____ The death of a family member.[2]

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[1]"Spouse" means individuals in a marriage, including "common law" marriage, same-sex marriage or same-sex individuals with a Certificate of Registered Domestic Partnership.

[2]Must be completed within 60 days of the date on which the eligible employee receives notice of the death of the family member.

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 OFLA for up to 12 workweeks of unpaid leave in a 12-month period for the reasons listed above.

OFLA requires that you be reinstated to the same position, or in some cases under state law, to an equivalent position. The district is not required to maintain benefits if you qualify for OFLA leave, unless provided otherwise by board policy or collective bargaining agreement; all such benefits will be restored in full upon your return to the district.

If you do not return to work following OFLA leave for a reason other than: (1) the continuation, recurrence or onset of a serious health condition which would entitle you to OFLA leave; 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 OFLA leave.

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

1. You are ☐ eligible ☐ not eligible for leave under the OFLA.

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

3. You ☐ will ☐ will not be required to furnish a medical certification of a serious health condition. If required, you must furnish the 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 OFLA leave. We ☐ will ☐ will not require that you substitute accrued paid leave for unpaid 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 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. You have a minimum ☐ 30-day ☐ Other: _____ (*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 canceled, **provided** we notify you in writing at least 15 days before the date that your health coverage will lapse. At our option, we may pay your share of the premiums during 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 OFLA leave.

5c. We ☐ will ☐ will not do the same with other benefits (e.g., life insurance, disability insurance, etc.) while you are on 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.

5d. In the event you do not return to work for the district after your 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.

6. You ☐ will ☐ will not be required to present a fitness-for-duty certification prior to being restored to employment following leave for your own serious health condition.

7. While on 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.

8. You are notified that all leave taken for the purposes of the death of a family member, counts toward the total period of authorized family leave.