South Wasco County School District 1

Code: **GCBDA/GDBDA-AR(2)**
Revised/Reviewed: 12/11/13

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 member[2] 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 or grandchild

Please state name and address of relation:

Name ______________________ Address ______________________

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[1]A 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 ____________________

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______ 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: ____________________

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______ 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 I am required to use any accrued paid leave, including personal and sick leave or accrued vacation leave before taking OFLA leave without pay. I may select the order in which the paid leave is used 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: ____________________