



FMLA/OFLA Designation

Date: _____
To: _____
From: _____
Subject: Family and Medical Leave Designation

WESD has made a determination about whether your request for leave qualifies under Federal Family and Medical Leave (FMLA), Oregon Family and Medical Leave (OFLA), or both leaves.

The following is the result of our review:

- FMLA OFLA
- Approved and Designated Not Approved (____)
- My own serious health condition Pregnancy, due date of (____)
- Family member's serious health condition (____) Parental Leave
- Family member injured while on active medical duty
- Qualifying exigency related to family member's active duty military call-up
- Bereavement Leave for death of a family member
- Other (____)

Currently, the following leave is available to you:

When your absence qualifies under both FMLA and OFLA leave, your entitlements run at the same time.

Under FMLA/OFLA _____ weeks, or _____ hours

Continuous: You are required to inform us if dates of scheduled leave change, are extended, or become known. Based on the information you have provided to date, you are taking your leave:

In a block of time from _____ to _____.

Intermittent: You will be absent approximately (______). Because your leave need will be unscheduled, it is not possible to provide the hours, days, or weeks that will be counted against your leave entitlement at this time.

On the specific dates that you take intermittent leave, please follow the call-in process for your department and record time in AESOP with FMLA in the remarks section.

Return to Work Certificate

If your leave is for your own serious health condition, you **are** **are not** required to provide WESD with a return to work certification upon your return from leave, verifying whether you are able to return to work, if you have any job-related restrictions and the duration of any restrictions. If you do not provide a return to work certification, your return to work may be delayed.