City of Sweet Home

HUMAN RESOURCES USE ONLY
Leave Request: ☐ FMLA ☐ OFLA ☐ Both
Employee Eligible: ☐ Yes ☐ No
☐ Original Request ☐ Revision ☐ Cancellation
Receipt by HR: _____

Request for FMLA/OFLA Leave

INSTRUCTIONS FOR EMPLOYEES: See page 2 of this form for explanation of qualifications for Federal Family and Medical Leave Act (FMLA) or Oregon Family Medical Leave (OFLA). If you have questions, call Human Resources for assistance (541-367-8969). This leave request must be completed if leave is used under the FMLA/OFLA. All leave qualifying as FMLA and/or OFLA will be counted as such.
Sign and submit this completed leave request to Human Resources, cpretty@sweethomeor.gov or Fax 541-367-1215.

Name: _____ Contact #: _____
Dept: _____ Job Title: _____
Supervisor: _____ Date of Hire: _____

Work Schedule:

☐ **Monday** ☐ **Tuesday** ☐ **Wednesday** ☐ **Thursday** ☐ **Friday** ☐ **Saturday** **Hours per Day:** _____

☐ **Full time** ☐ **Part time** **FTE:** _____

Begin Leave: _____ ***End Leave:*** _____

☐ Continuous **OR** ☐ Intermittent

Have you taken Family leave in the past 12 months? ☒ Yes ☐ No
If yes, previous date _____

Please indicate the reason for leave: ***(See page 2 for qualifying events)***

☐ My own serious health condition (employee must turn in the "Release to Work Authorization" form **prior** to returning to work)
☐ Family member's serious health condition, please identify family member . Parent of the Emplovee's Sam
☐ Sick child
☐ Parental Leave
☐ Pregnancy, please identify due date: _____ (employee must enroll new dependent with CIS within 60 days of birth)
☐ Family member injured while on active military duty
☐ Qualifying exigency related to family member's active duty military call-up
☐ Bereavement leave for death of a family member

Confidentiality: Any disclosure of medical information will be kept in a confidential file and will be used only for determining eligibility for OFLA/FMLA and tracking of leave.

FMLA/OFLA leave requests must be received in HR within 30 days of scheduled leave or if unexpected leave is requested, as soon as possible.

I understand that the City of Sweet Home requires me to use any accrued sick leave, vacation, personal leave days or other paid time established by City policy(ies) and/or collective bargaining agreement in the order specified by the City, and before taking leave without pay, for the family and medical leave period.] [I am required to use any accrued paid leave, including personal and sick leave or accrued vacation leave before taking family and medical leave without pay. I may select the order in which the paid leave is used 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 the City may terminate my employment. A fitness-for-duty statement may be required.

I authorize the City 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 the City's family and medical leave policy and a copy of my rights and responsibilities under the Family Medical Leave Act leave request form.

EMPLOYEE SIGNATURE: _____ Date: _____

INSTRUCTIONS FOR COMPLETION:
1. Ensure all applicable parts of the form are completed. Questions? Call 541-367-8969
2. Return signed form to Human Resources IMMEDIATELY at cpretty@sweethomeor.gov

ELIGIBLE EMPLOYEES

FMLA: Employees who worked for a total of at least 12 months (not necessarily consecutive) AND worked at least 1250 hours during the 12-month period.

OFLA: Employees who worked for a period of 180 calendar days immediately preceding the date leave begins, AND worked an average of 25 hours per week during the 180 day period (unless parental leave).

- **Exception 1: For parental leave, workers are eligible after being employed for 180 calendar days, without regard to the number of hours worked.**

- **Exception 2: For Oregon Military Family Leave, eligible workers must work for an employer an average of at least 20 hours per week, without regard to the number of days worked.**

A) FMLA/OFLA QUALIFYING EVENTS LIST

- Pregnancy Leave - taken prior to birth of child.
- Parental Leave - Adoption of a child up to age 18 (or older than 18 if incapable of self-care) or the newly placed foster child.
- Care of a newborn child (birth of a child). Employee must enroll new dependent with CIS within 60 days of birth.
- Family Member Leave:
    - Care of a spouse, parent, child of the employee (biological, adopted, foster or step child, a legal ward, or child of the employee standing in loco parentis), custodial parent, noncustodial parent, biological parent, adoptive parent, stepparent or foster parent, individual who was in loco parentis to the employee when the employee was a child, same-gender domestic partner, child of same-gender domestic partner, grandparent, grandchild, parent-in-law, or parent of the employee's same-gender domestic partner.
- To care for a sick child with an illness or injury that is not a serious health condition.
- Your own serious health condition (see item B1, B2, or B3 below).
- Family Member injured while on active military duty.
- Qualifying exigency related to family member's active duty military call-up.
- Bereavement Leave for death of a family member.
    - * see above under "Family Member Leave" for definition

B) FMLA/OFLA DEFINITION OF "SERIOUS HEALTH CONDITION"

1. An illness, injury, impairment or physical or mental condition that involves:
    - Inpatient care in a hospital, hospice or residential medical care facility (i.e. an overnight stay); including any period of incapacity (defined as an inability to work, attend school or perform other regular daily activities), or any subsequent treatment in connection with such inpatient care;

OR

2. Continuing treatment by a health care provider that includes **one OR more of the following**:
    - A period of incapacity of more than three consecutive calendar days, and any subsequent treatment or period of incapacity relating to the same condition, that also involves (i) treatment two or more times by a health care provider, or by a nurse or physician's assistant under direct supervision of a health care provider, or by a provider of health care services (e.g. physical therapist) on referral by a health care provider; or (ii) treatment by a health care provider on at least one occasion which results in a regiment of continuing treatment.
    - A period of incapacity due to pregnancy, or for prenatal care.
    - A period of incapacity or treatment for a "chronic" serious health condition which requires periodic visits for treatment by a health care provider continues over an extended period and may cause episodic rather than continuing period of incapacity (e.g., asthma, diabetes, epilepsy).
    - A period of incapacity which is permanent or long-term due to a condition for which treatment is not effective (e.g. Alzheimer's disease, severe stroke, terminal cancer).
    - A period of absence to receive multiple treatments for an injury or condition which would result in incapacitation of more than three days if not treated (e.g. chemotherapy or radiation for cancer, physical therapy for severe arthritis, or dialysis for kidney disease).

Note: Short-term conditions requiring only brief treatment and recovery are not "serious health conditions" (e.g. common cold, flu, earaches, upset stomach, minor ulcers, headaches other than migraines, routine dental or orthodontia problems and periodontal disease).

OR

3. An illness, disease or condition that in the medical judgment of the treating health care provider poses an imminent danger of death, is terminal in prognosis with a reasonable possibility of death in the near future or requires constant care.