Morrow County School District

Code: **GCBDA/ GDBDA-FORM(1)**
Adopted: 5/12/03
Revised: 9-8-08

Request for Family and Medical Leave

Employee Request for Family and Medical Leave (FMLA)
and/or Oregon Family Leave (OFLA)

PLEASE PRINT

Where the need for the leave may be anticipated, written request for family and medical leave must be made, if practical, at least 30 days prior to the date the requested leave is to begin. Failure to request leave in a timely manner could result in either the leave being postponed or the amount of leave available reduced 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 family or medical 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-sex domestic partner (OFLA leave only) ____ Child (including the biological, adopted or foster child, child of same-sex domestic partner 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) ____ Parent-in-law,

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

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

parent of employee's same-sex domestic partner, custodial parent, non-custodial parent, adoptive parent, foster parent, **Grandparent or Grandchild** (OFLA leave only.)

Please state name and address of relation:

Name _____ Address ____

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 work week) 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 a family leave in the past 12 months? _____ Yes _____ No
   If yes, how many workdays? _____

6. **A qualifying exigency arising from an employee's spouse, son, daughter, or parent who is on active duty, or has been notified of an impending call to active duty status, in support of a contingency operation.**

7. **To care for the serious illness or injury of a spouse, son, daughter, parent, or next of kin who is a covered service member. [Next of kin means the nearest blood relative of the eligible employee.]**

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 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 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 and/or federal law.

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

Signature of Employee: Date: _