

# Oregon School Boards Association Selected Sample Policy

Code: GCBDA/GDBDA-AR(2)  
Revised/Reviewed:

## 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 \_\_\_\_\_

Have you taken a family leave in the past 12 months?  Yes  No

If yes, how many work days? \_\_\_\_\_ Reason for leave \_\_\_\_\_

I request family or medical leave for one or more of the following reasons:<sup>1</sup>

1.  Because of the birth of my child and in order to care for him or her. (District: Use GCBDA/GDBDA-AR(3)(A) Certification Form)  
 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. (District: Use GCBDA/GDBDA-AR(3)(A) Certification Form)  
 Age of child \_\_\_\_\_ Date of placement \_\_\_\_\_  
 Leave to start \_\_\_\_\_ Expected return date \_\_\_\_\_
  
3.  In order to care for a family member<sup>2</sup> with a serious health condition. (District: Use GCBDA/GDBDA-AR(3)(B) Certification Form)  
 Leave to start \_\_\_\_\_ Expected return date \_\_\_\_\_  
 Please check one:  Spouse  Same-gender domestic partner (OFLA leave only)  Child<sup>3</sup>  Child of same-gender domestic partner (OFLA leave only)  Parent  Individual who was in loco parentis when the employee was a child  Parent-in-law (OFLA leave only)  Parent of employee's same-gender domestic partner (OFLA leave only)  Custodial parent  Noncustodial parent  Adoptive parent  Stepparent  Foster parent  Grandparent (OFLA leave only) or  Grandchild (OFLA leave only).

<sup>1</sup>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.

<sup>2</sup>"Family member," for purposes of FMLA and OFLA leave, means the spouse, custodial parent, noncustodial parent, adoptive parent, stepparent or foster parent, biological parent, child of the employee (biological, adopted, foster or step child, a legal ward, or child of the employee standing in loco parentis), same-gender domestic partner, the child of a same-gender domestic partner or a person with whom the employee is or was in a relationship of "in loco parentis." Additionally, when defining "family member" under OFLA (but not FMLA leave), this definition includes a grandparent, grandchild, parent-in-law same-gender domestic partner, the child of a same-gender domestic partner, or parent of the employee's same-gender domestic partner.

<sup>3</sup>For FMLA, the age of the son or daughter at the onset of disability is not relevant in determining a parent's entitlement to FMLA leave.

Please state name and address of relation:

Name \_\_\_\_\_ Address \_\_\_\_\_

Does the condition render the family member unable to perform daily activities?

\_\_\_\_\_

\_\_\_\_\_

- 4.  For a serious health condition which prevents me from performing my job functions. (District: Use GCBDA/GDBDA-AR(3)(A) Certification Form)

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:

\_\_\_\_\_

- 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).
- 6.  A qualifying exigency arising from an employee's spouse, son, daughter, or parent who is a covered servicemember as defined in GCBDA/GDBDA-AR(1), or leave for the spouse or domestic partner of a military personnel per each deployment of the spouse or domestic partner when the spouse or domestic partner has either been notified of an impending call to active duty, has been ordered to active duty, or has been deployed or on leave from deployment. (District: Use GCBDA/GDBDA-AR(3)(C) Certification Form)
- 7.  To care for a spouse, son, daughter, parent, or next of kin<sup>4</sup> who is a covered servicemember with a serious illness or injury incurred in the line of duty or active duty in the armed forces. Has leave been taken for the same servicemember and the same injury?  Yes  No (District: Use GCBDA/GDBDA-AR(3)(D) Certification Form) If yes, when was the leave taken and for how many work days? \_\_\_\_\_
- 8.  For the death of a family member (OFLA only).

I understand that [I may use accrued paid leave, including personal and sick leave or accrued vacation leave for the family and medical leave period.] (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.) 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 district may terminate my employment. (A fitness-for-duty statement may be required.)

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 and a copy of my rights and responsibilities under the Family Medical Leave Act leave request form.

Signature of Employee: \_\_\_\_\_ Date: \_\_\_\_\_

<sup>4</sup>"Next of kin" means the nearest blood relative of the eligible employee.

R10/24/136/25/15 | PHRS