Three Rivers School District

8550 New Hope Rd • PO Box 160 • Murphy, OR 97533

REQUEST FOR FAMILY AND MEDICAL LEAVE

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

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 the leave being postponed.

Name:____ Effective date of leave:______________

Bldg:_________________________________ 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. For the birth of my child and in order to care for him/her.

Expected date of birth:___________________ Actual date of birth:_______________________

Leave to start:__________________________Expected return date:______________________

_____ 2. For 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 _____Parent _____Parent-in-law, 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 relation:____

[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, non-custodial 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, grandchild 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."

Name:____

Describe the health condition:____
____

_____4. For a serious health condition which prevents me from performing my job functions.
Describe:____
____

Leave to start:_____________ Expected date of return:_________________________

***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 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 of next of kin[1] who is a covered service member.

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 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 paycheck any employee contributions for health insurance premiums, life insurance, or long-term disability insurance consistent with state and/or federal law. I understand that if I use all of my accrued leave and am placed on unpaid leave that it will be my responsibility to pay my portion of my health insurance premium directly each month.

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:____________

ADOPTED:
REVIEWED: New Policy