EMPLOYEE MEDICAL LEAVE

C H E C K L I S T

______1. ***Read the Leave Instructions*** *- on the following pages*

______2. ***Request for Medical Leave***
Due: At least 30 days in advance or immediately
Do NOT wait to submit your request until you have medical certification.
Obtain Supervisor/Administrator signature and forward to the Payroll Office.

______3. ***Certification of Health Care Provider***
Planned absence: This is due before starting your leave.
Unplanned absence: This is due within 15 days of first missing work.
Send/fax the completed form directly to the Payroll Office for medical confidentiality.

______5. ***Report your absences using your available paid leave***

You must use your available sick leave, personal leave, and vacation, if applicable, prior to taking unpaid leave.

______6. ***Return to Work Recommendation***

Due: One business day prior to returning

______7. ***Notify the District of any changes to your leave dates & confirm your return date***

Advise your administrator/supervisor and the Payroll Office by phone or email. Provide additional medical certification.

Please click the link below to read the Fern Ridge School District Board Policy on FMLA/OFLA:
http://policy.osba.org/fernridg/G/GCBDA_GDBDA%20R%20D1.PDF

Leave Related Contacts and Resources

Leaves of Absence: Phone: 541-935-2253 x1204 Fax: 541-935-8222
Email: dhughes@fernridge.k12.or.us

Employee Benefits: Phone: 541-935-2253 x1204 Fax: 541-935-8222
Email: dhughes@fernridge.k12.or.us

MEDICAL LEAVE

INSTRUCTIONS Submit all documents to the Payroll Office:

Fax: 541-935-8222 Phone: 541- 935-2253 x1204 Email: dhughes@fernridge.k12.or.us

DOCUMENTS: The ***Family Leave Packet*** contains the necessary forms. Send all documents to the Payroll Office.

REQUEST LEAVE: Complete the ***Leave of Absence Request Form*** as soon as your need for leave is known, with 30 days prior notice when possible.

MEDICAL CERTIFICATION: You must use the ***Certification of Health Care Provider*** form that is in the leave packet. You will need to complete the first part of the form and then have your healthcare provider complete the medical section. Send medical certification directly to the payroll office. This is due prior to your leave beginning or within 15 days that your need for leave becomes known. Your leave may not have FMLA/OFLA protected status if sufficient medical certification is not provided in a timely fashion. If there are extenuating circumstances that will not allow you to meet this deadline, please contact the Payroll Office.

REPORTING YOUR ABSENCES: You are required to follow normal absence reporting procedures, including Aesop, if applicable. If you are uncertain of your reporting responsibilities, please contact your Administrator/Supervisor or the school/department secretary.

REQUESTING LEAVE EXTENSIONS: If you wish to extend your leave, please submit an email request to both your Administrator and the Leaves of Absence coordinator at least 30 days prior to the end of your approved leave.
Additional Unpaid Leave: A request to take additional unpaid leave, beyond your FMLA and/or OFLA entitlement, requires the approval of your Administrator and Superintendent. Please submit your email request to them as soon as possible.

INTERMITTENT LEAVE: In addition to your normal absence reporting procedures:
Scheduled absences: You must advise your Administrator that it is part of your FMLA/OFLA leave and provide your Administrator with as much notice as possible. It is expected that you will schedule, to the best of your ability, leave-related appointments during your time off.
Unexpected absences: You must also inform your Administrator at the time of your absence, or within 24 hours of your return, that the absence is part of your FMLA or OFLA intermittent leave. Failure to do this will cause the absence to not maintain protected status. Follow normal absence reporting procedures.
You must keep a record/calendar of the absences that are part of this intermittent leave. This record must be sent to the Leaves of Absence coordinator on the last contract day of each month. See attached timesheet.
Intermittent leave is to be used for qualifying medical related reasons, in accordance with the physician's certification.
Changes to your leave: If the frequency or duration of your need to care for yourself or your family member changes, you will need to provide updated medical certification stating the medical reason for the change.

RETURN TO WORK: Please contact your administrator and the Payroll Office by email the week prior to your return to confirm your return date.

USE OF PAID LEAVE: The District requires you to use your available paid leave in the order of sick leave, personal leave, and then vacation, if applicable, while taking FMLA or OFLA leave. Once all paid leave is exhausted, your leave will be unpaid.

BENEFITS WHILE ON LEAVE: Your District-paid benefits will continue if you are in a paid status (i.e. sick leave) or on approved leave under FMLA/OFLA.

OTHER: Licensed employees: You are required to maintain licensure under TSPC while on leave. Failure to maintain an active TSPC license during your leave may impact your employment or paid status, if applicable.

Request for Family and Medical Leave

(Family and Medical Leave Act of 1993)
(Oregon Family Leave Act)

Fern Ridge School District

This request is required for family or medical absences of three or more workdays or for job protected leave under FMLA/OFLA qualifying reasons of less than 3 days.

1. *Complete this form in full; obtain your administrators/supervisors signature. Make a copy for your records.*
2. *Bring or fax the form immediately to the Payroll Office (541)935-8222.*

-Where the need for 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.
-If your leave was unforeseeable you must give the district oral notice as soon as practicable and provide Payroll with the completed form within 3 days of returning to work.

3. *Provide supporting medical certification/documentation to Payroll within 15 calendar days of your request, or before your leave begins.*

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: ______________________

Location: _________________________ Title: ____

Status: ☐ Full Time ☐ Part Time

Hire Date: _____________ Length of Service: _____________

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

If yes, how many days/weeks?______________ Reason for leave: ______________________________

I request family or medical leave for one or more of the following reasons:[2]

1. ☐ Because of 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. ☐ 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 with a serious health condition.[3]

Leave to start: _______________ Expected return date: _______________

Please check one:
☐Spouse[4] ☐Same-sex domestic partner (OFLA leave only)
☐Child ☐Child of same-sex domestic partner (OFLA leave only) Date of Brith:________________
☐Parent ☐Parent-in-law (OFLA leave only) ☐Parent of employee's same-sex domestic partner (OFLA leave only)
☐Custodial parent ☐Noncustodial parent
☐Adoptive parent ☐Foster parent ☐Stepparent
☐Grandparent or Grandchild (OFLA leave only)

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 Certification of Health Care Provider)
   Describe: ____
   Leave to start: _______________ Expected return date: _______________

Regarding 3 or 4 above, request intermittent (reduced workday hours) or reduced leave (fewer work days 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 a 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 service member as defined in GCBDA/GDBDA-AR, 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.

7. ☐ To care for a spouse, son, daughter, or next of kin[5] who is covered service member 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 service member and the same injury? ☐Yes ☐ No. 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 the district requires me to use any available accrued sick leave, personal leave or vacation days or other paid time established by Board policy(ies) and/or negotiated 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 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 work day 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 certification 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:** _______________

Administrator signature: ____ **DATE:** _______________

[2] 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.

[3] "Family member" for the purposes of FMLA and OFLA means the spouse, custodial parent, noncustodial parent, adoptive parent, step 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) 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), the definition includes a grandparent, grandchild, parents-in-law or the parents of the employee's registered domestic partner.
[4] "Spouse" means individuals in a marriage including "common law" marriage and same-sex marriage. For OFLA, spouse also includes same-sex individuals in a marrage including "common law" marriage and same-sex marriage.
[5] "Next of Kin" means the nearest blood relative of the eligible employee.

Certification of Health Care Provider

Employees Serious Health Condition

Fern Ridge School District

To be completed by the district:

The Family Medical Leave Act (FMLA) provides that a district may require an employee seeking FMLA leave protections because of a need for leave due to a serious health condition to submit a medical certification issued by the FMLA regulations. The district will maintain records and documents relating to medical certification, recertification's, or medical histories of employee's family members, created for FMLA purposes, as confidential medical records in separate files from personnel files and in accordance with 29 C.F.R. § 1635.9, if the Genetic Information Discrimination Act applies.

District contact person: ____________________________________

Employee's job title: ___________________________________ Regular work schedule: _______________

Essential job fuctions____

Check if job description is attached: ☐

To be completed by the employee:

Complete the information below before giving this form to your family member or his/her provider. The return of this form is required to obtain the benefit for FMLA protections. Failure to provide a complete and sufficient medical certification may result in denial of your FMLA request.

Return this completed form on ______________________________ (must be at least 15 days after employee is notified of this requirement).

Employee's name: ____

First Middle Last

To be completed by health care provider:

Your patient has requested leave under the FMLA. Answer, fully and completely, all applicable parts below. Several questions seek a response as to the frequency or duration of a condition, treatment, etc. Your answer should be the best estimate based upon your medical knowledge, experience and examination of the patient. Be as specific as you can; terms such as "lifetime," "unknown" or "indeterminate" may not be sufficient to determine FMLA coverage.
Limit your responses to the condition for which the employee is seeking leave. Do not provide information about genetic tests, as defined in 29 C.F.R. § 1635.3(f), genetic services, as defined in 29. C.F.R. § 1635.3(e) or the manifestation of disease or disorder in the employee's family members, as defined in 29 C.F.R. 1635.3(b). Extra space is provided, should you need it. Please be sure to sign the form on the last page.

Provider's name and business address: ____

Type of practice / Medical specialty: ____

Telephone: (________) ___________________ Fax: (_________)________________

Email:____

Medical Facts

1. The approximate date the condition commenced ____

The probable duration of the condition: ____

Was the patient admitted for an overnight stay in a hospital, hospice, or residential medical care facility?

☐Yes ☐No If yes, dates of admission: ____

List the date(s) you treated the patient for condition:
____

Was medication, other than over-the-counter medication, prescribed? ☐Yes ☐No

Will the patient need to have treatment visits at least twice per year due to the condition?
☐Yes ☐No

Was the patient referred to other health care provider(s) for evaluation or treatment (e.g., physical therapist)?
☐Yes ☐No
If yes, state the nature of such treatments and expected duration of treatment:
____
____

2. Is the medical condition pregnancy? ☐Yes ☐No
If yes, expected delivery date: ______________________

3. Use the information provided by the district in the "To be completed by district" section to answer this question. If the district fails to provide a list of employee's essential functions or a job description, answer these questions based upon the employee's own description of his/her job functions.

Is the employee unable to perform any of his/her job functions due to the condition:
☐Yes ☐No
If yes, identify the job functions the employee is unable to perform:
____

4. Describe other relevant medical facts, if any, related to the condition for which the employee seeks leave (such medical facts may include symptoms, diagnosis or any regimen of continuing treatment such as the use of specialized equipment):

____
____
____

Amount of leave needed

1. Will the employee be incapacitated for a single continuous period of time due to his/her condition, including any time for treatment and recovery? ☐Yes ☐No

If yes, estimate the beginning and ending dates for the period of incapacity: _________________________

____
____

2. Will the employee need to attend follow-up treatment appointments or work part-time or on a reduced schedule because of the employee's medical condition? ☐Yes ☐No

Estimate treatment schedule, if any, including the dates of any scheduled appointments and the time required for each appointment, including any recover period:

____

Estimate the part-time or reduced work schedule the employee needs, if any:
_____________hour(s) per day; ___________ days per week from _____________through_________________

3. Will the condition cause episodic flare-ups periodically preventing the employee from performing his/her job functions? ☐Yes ☐No

Is it medically necessary for the employee to be absent from work during the flare-ups?
☐Yes ☐No If yes, explain: ____
____

Based upon the employee's medical history and your knowledge of the medical condition, estimate the frequency of flare –ups and the duration of related incapacity that the employee may have over the next six months (e.g., one episode every three months lasting one to two days):

Frequency: _________times per ______ week(s) __________ month(s)

Duration: __________hours or _________day(s) per episode

ADDITIONAL INFORMATION: IDENTIFY QUESTION NUMBER WITH YOUR ADDITIONAL ANSWER.

____
____
____
____
____

_______________________________________ _________________________
Signature of Health Care Provider **Date**

Please return this form to the patient or FAX to Fern Ridge School District 28J Payroll Office at (541)935-8222.