EMPLOYEE MEDICAL LEAVE

Leave for your own serious health condition (including pregnancy)

C H E C K L I S T

This document provides general information regarding Fern Ridge School Districts administration of the FMLA and OFLA and is not intended to be the sole source of information regarding FMLA and OFLA.

______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 it to the Payroll Office.

______3. ***Are you planning on filing for Oregon Paid Family and Medical Leave Insurance?***

You must call The Hartford to start a claim at 1-888-301-5615 or fax in the claim form found at the back of this pakcet. Further information on PFMLI can also be found at the back of this packet.

______4. ***Certification of Health Care Provider*** (*This is not needed for maternity leave)*

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 see Board Policy GCBDA/GDBDA-AR(1) for more information on FMLA/OFLA

Leave Related Contacts and Resources

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

MEDICAL LEAVE

INSTRUCTIONS Submit all documents to the Payroll Office:

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

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

REQUEST LEAVE: Complete the ***Leave 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. 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 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 Payroll Office on the last contract day of each month. See attached intermittent timesheet, if approved.
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.

See District Policy, Association Contracts, and The Federal and Oregon Medical Leave Acts for detailed information.

Request 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 the Payroll Office with the completed form within 3 days of returning to work.

3. *Provide supporting medical certification/documentation to the Payroll Office 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.

Fern Ridge School District 28J

Code: GCBDA/GDBDA-AR(3)(A)
Revised/Reviewed: 4/19/21
Orig. Code: GCBDA/GDBDA-AR(3)(A

Certification of Health Care Provider

Employee's Serious Health Condition

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 employee's health care provider. Employees may not be asked to provide more information than allowed under the FMLA regulations. The district will maintain records and documents relating to medical certification, recertifications 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. § 1630.14(c)(1), if the Americans with Disabilities Act applies, 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: ______________________

Employee's essential job functions: ______________________________

____

Check if job description is attached: □

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

To be Completed by the Employee:

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

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 dates(s) you treated the patient for the 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 the District" section to answer this question. If the district fails to provide a list of the 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 medical 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

   If yes, are the treatments or the reduced number of hours of work medically necessary? □ Yes □ No

   Estimate treatment schedule, if any, including the dates of any scheduled appointments and the time required for each appointment, including any recovery 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 the question number with your additional answer):

____

____

____

____

____

____ ______________________________

Signature of health care provider Date

FMLA/OFLA Fitness-for-Duty

(Family and Medical Leave Act of 1993)

(Oregon Family Leave Act)

Fern Ridge School District

TO:
FROM: Payroll Office
DATE:
SUBJECT: Fitness-for-Duty Certification

Family and Medical Leave for your own serious health condition ends on or about_____________.
Prior to returning to work you must provide a Fitness-for-Duty Certification verifying whether you are able to return to work, if you have any job-related restrictions and the duration of any restrictions. Please take this Fitness-for-Duty Certification to your healthcare provider for completion. The district will use this Fitness-for-Duty Certification to determine if you are able to return to work after your leave.

Return the completed Fitness-for-Duty Certification to the district prior to the end of your Family and Medical Leave.

Fitness-for-Duty Certification

Health care Provider Completes this Section

Instructions: Please complete all sections in order for the district to determine if the employee is able to return to duty. The employee's position description or a list of essential duties ☐ is or ☐ is not attached to this form.

1. The employee is able to return to work full time without restrictions: ☐ Yes ☐No

   a. If yes, list the effective date________________________
   b. If no, complete the following:

      (1) The employee will be able to return to work with no limitation on __________________________.
      (2) I certify that from _____________________________to __________________________________
      the above named employee will be:

         (a) ☐ Unable to perform the physical requirements of their work; or
         (b) ☐ Is medically incapacitated: ☐ Totally ☐ Partially**

         **If partially medically incapacitated, complete the following:

         (c) Number of hours per day employee is able to work _________________________________
         (d) Number of days per week employee is able to work_________________________________

      (3) List any restrictions on the employee's work:
      ____
      ____
      ____

_______________________________________ _______________________
Printed name of health care provider Type of practice

_______________________________________ _______________________
Signature-health care provider Date

Health care provider: Please return the completed form to the employee/patient.

4/1/2014

EMPLOYEE RIGHTS

UNDER THE FAMILY AND MEDICAL LEAVE ACT

THE UNITED STATES DEPARTMENT OF LABOR WAGE AND HOUR DIVISION

LEAVE ENTITLEMENTS

Eligible employees who work for a covered employer can take up to 12 weeks of unpaid, job-protected leave in a 12-month period for the following reasons:

- The birth of a child or placement of a child for adoption or foster care;
- To bond with a child (leave must be taken within 1 year of the child's birth or placement);
- To care for the employee's spouse, child, or parent who has a qualifying serious health condition;
- For the employee's own qualifying serious health condition that makes the employee unable to perform the employee's job;
- For qualifying exigencies related to the foreign deployment of a military member who is the employee's spouse, child, or parent.

An eligible employee who is a covered servicemember's spouse, child, parent, or next of kin may also take up to 26 weeks of FMLA leave in a single 12-month period to care for the servicemember with a serious injury or illness.

An employee does not need to use leave in one block. When it is medically necessary or otherwise permitted, employees may take leave intermittently or on a reduced schedule.

Employees may choose, or an employer may require, use of accrued paid leave while taking FMLA leave. If an employee substitutes accrued paid leave for FMLA leave, the employee must comply with the employer's normal paid leave policies.

BENEFITS & PROTECTIONS

While employees are on FMLA leave, employers must continue health insurance coverage as if the employees were not on leave.

Upon return from FMLA leave, most employees must be restored to the same job or one nearly identical to it with equivalent pay, benefits, and other employment terms and conditions.

An employer may not interfere with an individual's FMLA rights or retaliate against someone for using or trying to use FMLA leave, opposing any practice made unlawful by the FMLA, or being involved in any proceeding under or related to the FMLA.

ELIGIBILITY REQUIREMENTS

An employee who works for a covered employer must meet three criteria in order to be eligible for FMLA leave. The employee must:

- Have worked for the employer for at least 12 months;
- Have at least 1,250 hours of service in the 12 months before taking leave;* and
- Work at a location where the employer has at least 50 employees within 75 miles of the employee's worksite.

*Special "hours of service" requirements apply to airline flight crew employees.

REQUESTING LEAVE

Generally, employees must give 30-days' advance notice of the need for FMLA leave. If it is not possible to give 30-days' notice, an employee must notify the employer as soon as possible and, generally, follow the employer's usual procedures.

Employees do not have to share a medical diagnosis, but must provide enough information to the employer so it can determine if the leave qualifies for FMLA protection. Sufficient information could include informing an employer that the employee is or will be unable to perform his or her job functions, that a family member cannot perform daily activities, or that hospitalization or continuing medical treatment is necessary. Employees must inform the employer if the need for leave is for a reason for which FMLA leave was previously taken or certified.

Employers can require a certification or periodic recertification supporting the need for leave. If the employer determines that the certification is incomplete, it must provide a written notice indicating what additional information is required.

EMPLOYER RESPONSIBILITIES

Once an employer becomes aware that an employee's need for leave is for a reason that may qualify under the FMLA, the employer must notify the employee if he or she is eligible for FMLA leave and, if eligible, must also provide a notice of rights and responsibilities under the FMLA. If the employee is not eligible, the employer must provide a reason for ineligibility.

Employers must notify its employees if leave will be designated as FMLA leave, and if so, how much leave will be designated as FMLA leave.

ENFORCEMENT

Employees may file a complaint with the U.S. Department of Labor, Wage and Hour Division, or may bring a private lawsuit against an employer.

The FMLA does not affect any federal or state law prohibiting discrimination or supersede any state or local law or collective bargaining agreement that provides greater family or medical leave rights.

For additional information or to file a complaint:

1-866-4-USWAGE

(1-866-487-9243) TTY: 1-877-889-5627

www.dol.gov/whd

U.S. Department of Labor | Wage and Hour Division

OREGON FAMILY LEAVE

You can take time off to take care of yourself or close family members under the Oregon Family Leave Act (OFLA).

- **This time is protected, but often unpaid unless you have vacation, sick, or other paid leave available.** Paid family leave will be available in 2023.
- To be eligible, you must have worked an average of 25 hours per week for 180 days - just 180 days for parental leave. Separation from employment or removal from the schedule for up to 180 days does not count against eligibility. During a public health emergency, you are eligible for all types of OFLA leave after working for at least 30 days prior at an average of at least 25 hours per week. Your employer must have at least 25 employees.
- You can take up to a total of 12 weeks of time off per year for any of these reasons.
  - **Parental leave** for either parent to take time off for the birth, adoption, or foster placement of a child. If you use all 12 weeks, you can take up to 12 more weeks for sick child leave.
  - **Serious health condition** of your own, or to care for a family member.
  - **Pregnancy disability leave** before or after birth of child or for prenatal care. You can take up to 12 weeks of this in addition to 12 weeks for any reason listed here.
  - **Military family leave** up to 14 days if your spouse is a service member who has been called to active duty or is on leave from active duty.
  - **Sick child leave** for your child with an illness, injury or condition that requires home care but is not serious, or to care for a child whose school or place of care is closed because of a public health emergency.
  - **Bereavement leave** for up to 2 weeks after the death of a family member.
- Your employer must keep giving you the same health insurance benefits as when you are working. When you come back you must be returned to your former job or a similar position if your old job no longer exists.

CONTACT US

If your employer isn't following the law or something feels wrong, give us a call. The Bureau of Labor and Industries is here to enforce these laws and protect you.

Call: 971-673-0761
Email: help@boli.state.or.us
Web: oregon.gov/boli
Se habla español.

YOUR EMPLOYER'S PAID LEAVE EQUIVALENT PLAN

WHAT YOU NEED TO KNOW

Starting in September 2023, Paid Leave Oregon will serve most employees in Oregon by providing you paid leave for the birth, adoption, or fostering of a child; when you or a loved one is impacted by a serious illness or injury; or if you or your child is experiencing a situation with sexual assault, domestic violence, harassment, or stalking. Your employer has been approved to offer these paid leave benefits through an equivalent plan. This means that your paid leave benefits will come from your employer or plan administrator.

WHAT BENEFITS ARE PROVIDED THROUGH MY EMPLOYER'S EQUIVALENT PLAN AND WHO IS ELIGIBLE?

Oregon employees may be entitled to up to 12 weeks of paid family, medical, or safe leave in a benefit year. While on leave, you will be paid a percentage of your wages. Benefit amounts will depend on what you've earned in the prior year.

WHO PAYS FOR EQUIVALENT PLANS?

Starting on September 3, 2023, Oregon employees will contribute to their employer's Equivalent Plan through payroll taxes. Contributions are calculated as a percentage of wages and your employer will deduct your contribution from your paycheck.

WHEN DO I NEED TO TELL MY EMPLOYER ABOUT TAKING LEAVE?

If your leave is foreseeable, you are required to give notice to your employer at least 30 days before starting paid family, medical, or safe leave.

HOW DO I APPLY FOR PAID LEAVE UNDER THE EQUIVALENT PLAN?

Starting September 3, 2023, you may be entitled to paid leave benefits under your equivalent plan by applying as follows:

Calling The Hartford at: 888-301-5615; or

Completing the claim form provided by your employer with input from your employer and the provider.

Mail or fax the documentation to:
The Hartford
PO Box 14869
Lexington, KY 40512
Fax: 833-357-5153

HOW CAN I APPEAL MY EMPLOYER'S DECISION?

If your application is denied, you can appeal the decision with your plan administrator. To appeal the decision with The Hartford you must submit in writing, as indicated in your decision letter.

HOW DO I DISPUTE MY EMPLOYER'S DECISION?

If the appeal does not resolve your disagreement, you can request support from Paid Leave Oregon for dispute resolution. Visit paidleave.oregon.gov or call 888-854-0166 for more information.

WHAT ARE MY RIGHTS?

If you are eligible for paid leave, your employer cannot prevent you from taking it. Your job is protected while you take paid leave if you have worked for your employer for at least 90 consecutive calendar days. You will not lose your pension rights while on leave and your employer must give you the same health benefits as when you are working.

HOW IS MY INFORMATION PROTECTED?

Health information related to family, medical, or safe leave that you choose to share with your employer is confidential and can only be released with your permission, unless the release is required by law.

WHAT IF I HAVE QUESTIONS ABOUT MY RIGHTS?

It is unlawful for your employer to discriminate or retaliate against you because you asked about or claimed paid leave benefits. If your employer is not following the law, you have the right to bring a civil suit in court or to file a complaint with the Oregon Bureau of Labor & Industries (BOLI). You can file a complaint with BOLI online, via phone or email:

Web: www.oregon.gov/boli
Call: 971-245-3844
Email: help@boli.oregon.gov

Learn more about our Equivalent Plan:
Please contact your Employee Benefits Administrator

THE HARTFORD

Business Insurance
Employee Benefits
Auto
Home

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1571975k 05/23

HOW TO FILE FOR OREGON PAID FAMILY AND MEDICAL LEAVE INSURANCE WITH CONFIDENCE

Your OR PFMLI claim is managed by The Hartford. It's a user-friendly benefit that helps provide essential support services while you're away from your workplace.

Lane County School District 28J

135140

Follow these steps to file a claim with The Hartford:

STEP 1: KNOW WHEN IT'S TIME TO FILE A CLAIM

If you're absent from work, we can advise you on when to file a claim.

- If your absence is scheduled, file your claim within 30 days of your last day of work. (For example, an upcoming hospital stay)
- If your absence is unscheduled, follow your employer's call out policy and file your claim as soon as possible.

STEP 2: HAVE THIS INFORMATION READY

- Name, address, policy number, and other key identification information.
- Name of your department and last anticipated day of active full-time work.
- The nature of your claim.
- When applicable, your treating physician's name, address, phone and fax numbers.

STEP 3: FILE YOUR CLAIM

With your information handy, file a claim by: Calling The Hartford at **888-301-5615** ; or Completing the claim form provided by your employer with input from your employer and the provider. Mail or fax the documentation to:

The Hartford
PO Box 14869
Lexington, KY 40512
Fax Number: 833-357-5153

Please cut here and keep in your wallet.

TO FILE AN OR PFMLI CLAIM

888-301-5615
Policy Number: 135140

If you're absent from work, we can advise you on when to file a claim. If your absence is scheduled, such as an upcoming hospital stay, call us within 30 days of your last day of work. If unscheduled, please call us as soon as possible.

You'll be assisted by a caring professional who'll take your information, answer your questions and help you file your claim or process your leave request.

GET SUPPORTIVE ASSISTANCE

After your claim has been filed, we may be in touch to check your progress, answer questions or obtain additional information from you.

Our goal is to offer a smooth and hassle-free experience until you return to work. Feel free to call us with anything that's on your mind. We're here to help.

Product	OR PFMLI
Employer Name	Lane County School District 28J
Policy Number	135140
Phone Number	888-301-5615

FOR MORE INFORMATION, PLEASE CONTACT THE HARTFORD'S TOLL-FREE NUMBER 888-301-5615

Business Insurance
Employee Benefits
Auto
Home

Statutory Paid Family and Medical Leave Form Series included GBD-1858 PFML (OR).

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1984850 08/23

WHEN YOU CALL, THE HARTFORD WILL ASK YOU TO PROVIDE

Name, address, policy number and other key identification information.

- Name of your department and last day of active work.
- The nature of your claim.
- Your treating physician's name, address, phone and fax numbers.

This card is not proof of insurance
1984850a 08/23

Fax or mail completed application to:
The Hartford
P.O.Box 14869
Lexington, KY 40512-4869
Fax Number: (833) 357-5153

NOTICE OREGON PAID FAMILY AND MEDICAL INSURANCE (OR PFMLI)

PART A CLAIMANT INFORMATION TO BE COMPLETED BY THE CLAIMANT - PRINT OR TYPE

1. Name: (Last, First, Middle) as shown on your Social Security card:
2. Social Security Number:
3. Birth Date:

4. Gender: Male / Female / Not Designated /Other
5. Home/Cell Number:
6. Marital Status: Single / Married
7. Preferred E-Mail Address while on leave:

8. Mailing address: (Street, City or Town, State, Zip Code)

9. Employer Name:
10. Employer Telephone Number:

11. Employer Address: (Street, City, State & Zip Code)
12. Occupation:

13. Reason for Leave:

- Own Serious Health Condition
- Care of Family Member with a serious health condition
- Bond with a Child
- Safe Leave for myself due to domestic violence, harassment sexual assault, or stalking
- Safe Leave for my child due to domestic violence, harassment sexual assault, or stalking

14. If leave is to care for a family member, the family member is the employee's:

* "Relationship" includes "biological, foster, adoptive, step, and in loco parentis relationships.

- Self
- Spouse
- Domestic Partner
- Parent
- Child
- Grandparent or Grandparent's Spouse/Domestic Partner
- Grandchild or Grandchild's Spouse/Domestic Partner
- Sibling or Sibling's Spouse/Domestic Partner
- Spouse's Parent/Domestic Partner
- Child's Spouse/Domestic Partner
- Any individual related by blood or affinity whose close association with employee is equivalent of a family relationship

Name of family member: Date of Birth

15. Will leave be for a continuous period of time and/or intermittent (periodic) or a reduced work schedule?
Identify dates intermittent leave will likely be taken if applicable

Continuous	Start Date:	End Date:
Intermittent	Start Date:	End Date:
Reduced Schedule	Start Date:	End Date:

16. Date notice provided to Employer:

If providing less than 30 days' advance notice to the employer, please explain:

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PART A (Continued)

Other Employment information - If you worked for other employers in Oregon during the past five (5) quarters besides the Employer identified in question 9 above, complete the below information. Include full-time and part-time employment. If you had more than 2 employers, list on a separate sheet and attach to this form. Please include wages received for the last five completed calendar quarters immediately prior to the start date of the leave request. A calendar quarter is January – March, April – June, July – September and October – December. Hours worked should reflect total hours worked within each calendar quarter.

17. Other Employer Name: 18. Telephone Number:

19. Period of Employment From: To: 20. Address:

	CALENDAR QUARTER	TOTAL GROSS EARNINGS	TOTAL WEEKS WORKED
1			
2			
3			
4			
5			

21. Other Employer Name: 22. Telephone Number:

19. Period of Employment From: To: 24. Address

	CALENDAR QUARTER	TOTAL GROSS EARNINGS	TOTAL WEEKS WORKED
1			
2			
3			
4			
5			

25 Certification and Signature

I was unable to work during the period for which I am claiming benefits, and I hereby certify that I have read and understand my benefits rights. I also certify that the information I completed on this form are true and accurate. I am aware that if any of the information I completed on this form are knowingly false, I may be subject to penalties which may include criminal prosecution. I am hereby authorizing you to obtain any medical, employment and wage information you need to determine my eligibility for this benefit, and to share any such information with my employer as may be necessary to process benefits and in accordance with applicable law.

If your employer has agreed to continue your regular pay while you are unable to work, do you agree to have the benefits available to you under this policy routed through your employer?

Yes No Please Sign:

Note: A "No" answer could impact you continuing to receive your regular pay from your employer in exchange for the benefits available to you from this policy.

Any person who knowingly files a statement of claim containing any false or misleading information is subject to criminal and civil penalties. Any person who includes any false or misleading information on an application for insurance policy is subject to criminal and civil penalties.

Electronic Funds Transfer (EFT) is our standard method of benefit payment. When making our claim decision we may contact you to obtain your banking information.

SIGN HERE

(Claimant's Signature) (Date)

SIGN HERE

(Employer Signature) (Date)

Certification of Serious Health Condition

Oregon Paid Family and Medical Insurance (OR PFMLI)

Section I - For Completion by Employee: Complete the Employee Information section and give it to your/your family member's health care provider to complete. Have your/your family member's provider return it to you. You will need to return this form to The Hartford as soon as possible so that we can evaluate your claim.

Forms can be mailed to: The Hartford
P. O. Box 14869
Lexington, KY 40512-4869

OR Fax to: The Hartford
(833) 357-5153

Employee Information

Employee's Name: Last 4 digits of Social Security Number:

Claim Number: Date of Birth:

Employer's Name: Today's Date:

Employee's Job Title: Regular Work Schedule:

Additional Pregnancy Leave:
This option is only available if you are taking family-bonding leave or medical-pregnancy leave.
Are you currently pregnant or have you given birth in the last year, and are you asking for an additional two weeks of leave for health issues related to pregnancy, childbirth, or a related medical condition?

Yes No

If you are not currently pregnant, please provide the date that your pregnancy ended:

If you are applying to care for a family member complete the information below.

The family member who is experiencing a serious health condition is my:

- Spouse
- Domestic Partner
- Parent
- Child
- Any individual related by blood or affinity whose close association with employee is the equivalent of a family relationship
- Grandchild or Grandchild's Spouse/Domestic Partner
- Sibling or Sibling's Spouse/Domestic Partner
- Spouse's Parent/Domestic Partner
- Child's Spouse/Domestic Partner
- Grandparent or Grandparent's Spouse/Domestic Partner

Family Member's Full Name: Date of Birth:

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Section II - For Completion by the Health Care Provider: (See Part A and Part B attached)
INSTRUCTIONS to the HEALTH CARE PROVIDER: Please read the definition of a serious health condition below and refer to it while filling out the form. This form should be filled out by the healthcare provider of the patient, who may or many not be the employee. For the employee to qualify for paid leave, the patient must have a serious health condition. Answer all questions fully and completely.

The Genetic Information Nondiscrimination Act of 2008 (GINA) prohibits employers and other entities covered by GINA Title II from requesting or requiring genetic information of an individual or family member of the individual, except as specifically allowed by this law. To comply with this law, we are asking that you not provide any genetic information when responding to this request for medical information. "Genetic information" as defined by GINA, includes the manifestation of disease or disorder in family members of the individual, an individual's family medical history, the results of an individual's or family member's genetic tests, the fact that an individual or an individual's family member sought or received genetic services and genetic information of a fetus carried by an individual's family member or an embryo lawfully held by an individual or family member receiving assistive reproductive services.

Provider's name:

Provider's Business Address:

Type of Practice/Medical Specialty:

Telephone Number: Fax Number:

Definition of a Serious Health Condition
Serious Health Condition means an illness, injury, impairment, or physical or mental condition of a Covered Individual or their Family Member that:

1. requires inpatient care in a medical care facility such as, but not limited to, a hospital, hospice, or residential facility such as, but not limited to, a nursing home or inpatient substance abuse treatment center;

2. in the medical judgment of the treating Health Care Provider poses an imminent danger of death, or that is terminal in prognosis with a reasonable possibility of death in the near future;

3. requires constant or continuing care, including home care administered by a health care professional;

4. involves a period of incapacity. "Incapacity" is the inability to perform at least one essential job function, or to attend school or perform regular daily activities for more than three consecutive calendar days. A period of incapacity includes any subsequent required treatment or recovery period relating to the same condition. The incapacity must involve one of the following:
   a. two or more treatments by a Health Care Provider; or
   b. one treatment plus a regimen of continuing care.

5. results in a period of incapacity or treatment for a chronic Serious Health Condition that requires periodic visits for treatment by a Health Care Provider, continues over an extended period of time, and may cause episodic rather than a continuing period of incapacity, such as, but not limited to, asthma, diabetes, or epilepsy;

6. involves permanent or long-term incapacity due to a condition for which treatment may not be effective, such as, but not limited to, Alzheimer's Disease, a severe stroke, or terminal stages of a disease. The Covered Individual or Family Member must be under the continuing care of a Health Care Provider, but need not be receiving active treatment;

7. involves multiple treatments for restorative surgery or for a condition such as, but not limited to, chemotherapy for cancer, physical therapy for arthritis, or dialysis for kidney disease that if not treated would likely result in incapacity of more than three calendar days;

8. involves any period of disability due to pregnancy, childbirth, miscarriage or stillbirth, or period of absence for prenatal care;

9. involves any period of absence from work for the donation of a body part, organ, or tissue, including preoperative or diagnostic services, surgery, post-operative treatment, and recovery.

PART A - Patient's Serious Health Condition (For Completion by the Health Care Provider)

1) Does the patient have a serious health condition? Yes No

2) Which of the following apply to the patient's serious health condition (Check all that apply)

Requires or required inpatient care

Poses danger of death or is terminal in prognosis

Requires constant or continuing care, including home care administered by a health care professional

Involves a period of incapacity. "Incapacity" is the inability to perform at least one essential job function, or to attend school or perform regular daily activities for more than three consecutive calendar days. A period of incapacity includes any subsequent required treatment or recovery period relating to the same condition. The incapacity must involve one of the following: two or more treatments by a Health Care Provider; or one treatment plus a regimen of continuing care.

Results in a period of incapacity or treatment for a chronic Serious Health Condition that requires periodic visits for treatment by a Health Care Provider, continues over an extended period of time, and may cause episodic rather than a continuing period of incapacity, such as, but not limited to, asthma, diabetes, or epilepsy

Involves permanent or long-term incapacity due to a condition for which treatment may not be effective

Involves multiple treatments and if not treated would result in incapacity

Involves any period of disability due to pregnancy, childbirth, miscarriage or stillbirth, or period of absence prenatal care

Involves any period of absence from work for the donation of a body part, organ, or tissue, including preoperative or diagnostic services, surgery, post-operative treatment, and recovery

3) If the patient is a family member, will the patient require care from the employee seeking leave as the result of their serious health condition?

Yes No

4) Provide appropriate medical facts to allow an understanding of how the condition may affect the patient. Examples may include symptoms, hospitalizations, medical visits, relevant side effects to medication, and referrals for evaluation or treatment.

5) When did the condition begin? This is the start of the condition, not the start of the employee's leave from their job. If it cannot be determined, provide a start date to the best of your ability.

This condition began within the past 12 months.

Start Date: This condition began more than one year ago.

6) Is the patient's serious health condition a pregnancy-related issue that results in some level of incapacity prior to giving birth?

Yes Expected delivery No

7) Is this health condition a job-related injury? Yes No

PART B - Ability to Work: (For Completion by the Health Care Provider)

Provide your best estimate based on your medical knowledge, experience, and examination of the patient. Be as specific as you can be: terms like "unknown" or "indeterminate" may not be enough to approve a claim for paid leave benefits. This section establishes the start and end dates when the employee needs leave due to their own incapacity or the incapacity of a family member because of the serious health condition. The date range is the leave period. A leave cannot be approved for longer than 12 months. If the condition requires additional leave after 12 months or a re-evaluation, the employee can submit a new application at that time with a new certification. OR PFML must be taken in full day increments.

1) When will the employee first need to take leave? This is the first day full day of time missed from work. If any time has already been missed because of this condition, enter the earliest absence.

Start Date:

2) Do you know the last day the employee will need leave for the patient's condition? If you cannot determine this, when do you recommend re-evaluating? (Check only one)

Yes The last day the employee will need leave is:

No The patient's condition should be re-evaluated on:

3) During this leave period, which of these patterns of leave do you expect the employee to need as a result of the patient's condition?

Continuous leave (e.g., Completely unable to work for consecutive, uninterrupted days)

Reduced leave schedule (e.g., A consistent but reduced schedule for multiple weeks)

Intermittent leave (e.g., Episodic time off at irregular intervals for flare-ups or unexpected aftercare)

4) **Continuous leave needed:** When will the continuous leave period start and end?

Start Date: End Date:

Reduced leave schedule needed: When will the reduce leave schedule start and end?

Start Date: End Date:

How many days should the employee take off per week? Days per week

Intermittent leave needed: When will the intermittent leave schedule start and end?

Start Date: End Date:

Estimate the frequency and duration of intermittent leave needed, if any, over the next 12 months including any recovery period:

Frequency: times per week(s) or month(s)

Duration: day(s) per episode/treatment

Dates of scheduled treatment(s)/appointment(s):

PART B - Ability to Work: (For Completion by the Health Care Provider) - Continued

I certify that the information provided in this form is true and correct, that I have examined the patient and answered the questions accurately and to the best of my ability, and that I am a health care provider authorized to certify their condition.

Signature of Health Care Provider **Date**

Signature of Employee **Date**

Notice of Oregon Paid Family and Medical Leave Insurance

Part C: TO BE COMPLETED BY YOUR EMPLOYER

1. Employee Name:

2. Employee ID:

3. Employment Status: If terminated, provide Active Terminated date of termination:

4. Last Date Worked:

5. First Date of Absence:

6. Did employee work a full day? Yes No If No, how many hours did they work?

7. Did this employee meet the definition of an Oregon Employee / Worker: Yes No

Note: Employees can be eligible for OR PFMLI benefits only while employed as defined by Oregon Paid Family and Medical Leave Law. You'll need to contact us immediately if there is any change in their OR employment status.

8. Please provide the number of days the employee worked per week in the 12 week prior to the leave start date:

Week Ending	Month	Day	Year	# of days worked
Week 1				
Week 2				
Week 3				
Week 4				
Week 5				
Week 6				
Week 7				
Week 8				
Week 9				
Week 10				
Week 11				
Week 12				
				Total 0.0

9. Will you be making payments to the employee from a qualifying employer sponsored policy or program (not accrued paid leave)that are equal to or greater than the OR PFMLI benefit while on leave? Yes No

If yes, will you be requesting reimbursement* for payments to the employee during their Paid Medical Leave:

Yes No If yes, what are the dates? From Through

***Note for employees with multiple Oregon employers only:* In the unlikely event that OR PFML law's method of prorating benefits between employers will entitle an employee to a greater benefit amount than you paid your employee through your employer sponsored policy or program. We don't know the exact amount you are paying your employee for this leave. So, if we reimburse you for an amount greater than the amount you paid your employee, you will be required to reconcile the difference in PFML benefits owed to your employee and the amount you paid during their Paid Medical Leave.**

Part C (Continued):

10. As of 9/3/23 or later has this employee used unpaid Oregon Family Leave Act (OFLA)?
Yes No If yes, please provide the following:

Leave Reason: ________________ Time Used: ________________ Date(s): ______________

Leave Reason: ________________ Time Used: ________________ Date(s): ______________

Leave Reason: ________________ Time Used: ________________ Date(s): ______________

Leave Reason: ________________ Time Used: ________________ Date(s): ______________

Leave Reason: ________________ Time Used: ________________ Date(s): ______________

---

11. Has the employee filed for or received:
Workers' Compensation benefits Yes No Unemployment Benefits Yes No

---

12. Please provide all Wages as defined in the Oregon Paid Family and Medical Leave Law
Provide five completed calendar quarters of earnings preceding the employee's start date of leave, with the most recent quarter as outlined below. If they do not have a full five quarters, only provide the most recent four completed quarters.

PREVIOUS COMPLETED QUARTERS	CALENDAR QUARTER DATES	TOTAL EARNINGS
5 (most recent quarter)		
4		
3		
2		
1		

If the employee has fewer than four completed calendar quarters, please advise the number of completed weeks/earnings for those completed weeks.

NUMBER OF WEEKS WORKED WITH EARNINGS	TOTAL EARNINGS

---

13. Will the employer be requesting reimbursement? Yes No
If Yes, please provide the dates: From: Through:

Completed By: Job Title: Phone Number:

Signature of Employer: Date:

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