Canby School District
EMPLOYEE LEAVE REQUEST

This form is required for any absence that extends for a period of more than five (5) days

Employee Name: _____

Assignment/Job Title: _____ Work Site: _____

Home Address: _____ Home Phone: _____

City/State/Zip: _____ Work Phone: _____

A. Instructions for Employees – **You must complete an Employee Leave Request form (sections B - D) for any absence of more than five (5) workdays**. Submit the completed form to your supervisor. Without a supervisor's signature, your leave request may be delayed. Complete this form before leave is taken to ensure it has been approved. Human Resources (HR) may need to ask for additional information to determine FMLA/OFLA eligibility. See page three (3) of form for explanation of qualifications for FMLA/OFLA. Leave which does not qualify as FMLA and/or OFLA may still be taken subject to Board Policy and applicable negotiated agreements.

B. Request for Leave **Is this leave intermittent? ☐ Yes ☐ No**

1. Beginning Date of Absence:_____ Anticipated Return to Work Date: _____
2. I am requesting leave for ☐ full-time/all of my assignment OR ☐ part-time/FTE or hours per day/week: _____

C. Reason for Leave – Documentation to be submitted to the Human Resources Department ONLY.

MEDICAL / FAMILY MEDICAL / PREGNANCY / PARENTAL LEAVE - Please check the appropriate box

- ❑ My own serious health condition: ***Completed Certification of Health Care Provider form must be submitted to Human Resources ONLY.***
- ❑ Pregnancy: ***Written medical documentation from a health care provider must be submitted to Human Resources.***
- ❑ A serious health condition for which you are needed to provide care for an immediate family member: Relationship of family member: _____. ***Completed Certification of Health Care Provider form, or other medical documentation from your family member's health care provider must be submitted to Human Resources.***
- ❑ Parental Leave for the birth or adoption of a child: Only a Leave Request Form required. Expected date of birth and/or expected date of physical custody:_____.
- ❑ Parental Leave/Foster Care: You must register a document showing legal guardianship. Date of birth and/or expected date of physical custody:_____.
- ❑ An illness or injury that is not a serious health condition affecting your child during which you are needed to provide home care.

OTHER LEAVE – Please check the appropriate box

- ❑ Association/Union: Verification of contractual arrangements must be provided to Human Resources.
- ❑ Employment in an Institution of Higher Learning (CEA only): Specifics of leave and/or verification of contractual arrangements must be provided to Human Resources.
- ❑ Exchange and Other Teaching (CEA only): Specifics of leave and/or verification of contractual arrangements must be provided to Human Resources.
- ❑ Military: Military Orders must be provided to Human Resources.
- ❑ Political: Specifics of leave and/or verification of contractual arrangements must be provided to Human Resources.
- ❑ Sabbatical (CEA only) Specifics of leave and/or verification of contractual arrangements must be provided to Human Resources.
- ❑ Unpaid: You must attach a written statement on a separate sheet explaining your reason for an unpaid leave of absence.

NOTE: If you are requesting an altered or reduced work schedule for medical reasons, either for yourself or a family member, please indicate your scheduling needs here:

_____

_____

D. SUPERVISOR ACKNOWLEDGEMENT – My signature below indicates ONLY that I have been notified of this employee's request for a leave of absence. I understand that an employee's or family member's medical information is confidential, and that all medical documentation should be provided ONLY to the Human Resources Department.

_____	_____	_____
Supervisor Name (please print)	Supervisor Signature	Date

(Special Education and ELL: Please forward to the Director of Student Services or Director of Teaching and Learning so they can be advised and sign this form as well)

_____	_____	_____
Supervisor Name (please print)	Supervisor Signature	Date

E. EMPLOYEE SIGNATURE My signature indicates that I understand it is my responsibility to contact Human Resources (503-266-0011) for information regarding continuation of my district provided health and welfare benefits. Should I choose to continue insurance benefits on a self-pay basis, it is my responsibility to call Human Resources regarding options for continuation of benefits on a self-pay basis during my unpaid leave. When I return from unpaid leave, it may be necessary to complete new insurance forms to reinstate the District's contribution for my coverage. This is true whether or not I self-pay for benefits while on leave.

If I am a licensed employee requesting unpaid leave, I must inform Human Resources in writing, no later than March 15th of my intention to return at the beginning of the school term following the expiration of my leave.

_____	_____	_____
Employee Name: (please print)	Employee Signature	Date

PLEASE RETURN COMPLETED FORM WITH THE APPROPRIATE MATERIALS TO:

Department of Human Resources / Canby School District /1130 S Ivy St / Canby, OR 97013 or
fax to 503-266-0024
If you have questions, please call 503-266-0011

FOR HUMAN RESOURCES USE ONLY

Total of accumulated paid leave as follows:

_____ Hours of full paid sick leave

_____ Hours of Emergency/Personal Business Leave

_____ Hours of paid vacation (if applicable)

Eligible paid leave from: _____ through _____

Eligible unpaid leave from: _____ through _____

FMLA – Eligible Dates: _____ Not Eligible / Reason: _____

OFLA Medical – Eligible Dates: _____ Not Eligble / Reason: _____

OFLA Parental – Eligible Dates: _____ Not Eligible / Reason: _____

HR Approval: _____ Date: _____

"SERIOUS HEALTH CONDITION"

Introduction

OFLA and FMLA have similar definitions for "serious health condition." They define "serious health condition" as an illness, injury, impairment, or physical or mental condition that falls into one or more categories based primarily on the severity of the serious health condition and the type of medical treatment involved. Among the categories are inpatient care, terminal illness, constant or continuing treatment, pregnancy-related conditions, chronic conditions, and conditions requiring multiple treatments. However, within those categories, there are some important differences, noted below. ORS 659A.150(6), OAR 839-009-0210(20), 29 CFR §825.113 - .115, §825.120, §825.800.

The chart below compares the definitions and qualifying conditions necessary for an employee to meet the definitions of "serious health condition" in OFLA and FMLA.

OFLA "SERIOUS HEALTH CONDITION"	**FMLA "SERIOUS HEALTH CONDITION"**
1. An illness, injury, impairment or physical or mental condition that requires inpatient care in a hospital, hospice, or residential medical care facility. ORS 659A.150(6)(a), OAR 839-009- 0210(20)(a)	1. An illness, injury, impairment or physical or mental condition that requires an overnight stay in a hospital, hospice, or residential medical facility, including any period of incapacity, or any subsequent treatment in connection with such inpatient care. 29 CFR §825.114
2. An illness, injury, impairment or physical or mental condition that: • Requires "constant" or "continuing" care such as home care administered by a health care provider; or • Involves a period of incapacity for more than three consecutive calendar days and two or more treatments by a health care provider or one treatment plus a regimen of continuing care; or • Involves permanent or long-term incapacity for which treatment may not be effective, such as Alzheimer's disease, a severe stroke, or terminal stages of disease. The employee or family member must be under the continuing care of a health care provider but need not be receiving active treatment. OAR 839-009-0210(20)(c)(d)(f)	2. An illness, injury, impairment or physical or mental condition involving continuing treatment, a period of incapacity for more than three consecutive, full calendar days, and: • In-person treatment two or more times within 30 days of the first day of incapacity, unless extenuating circumstances exist, by a health care provider, with the first visit within seven days of incapacity; or • in-person treatment by a health care provider on at least one occasion that results in a period of continuing treatment under the health care provider's supervision, with the first visit within seven days of the first day of incapacity. 29 CFR §825.115(a)
3. An illness, injury, impairment or physical or mental condition that results in a period of incapacity or treatment for a chronic serious health condition that requires periodic visits for that treatment by a health care provider, continues over a period of time, and may cause episodic rather than a continuing period of incapacity, such as asthma, diabetes, or epilepsy. OAR 839-009- 0210(20)(e)	3. A chronic condition that requires at least two visits a year for treatment by a health care provider, continues over an extended period of time, and may cause episodic instead of a continuing period of incapacity. 29 CFR §825.115(c)

4a. An illness, disease or condition diagnosed as terminal with a reasonable possibility of death in the near future. 4b. An illness, disease or condition diagnosed as posing an imminent danger of death. ORS659A.150(6)(b), OAR 839-009-0210(20)(b)	4. Permanent or long-term conditions for which treatment may not be effective, e.g. Alzheimer's disease, stroke, terminal stages of a disease. 29 CFR §825.115(d)
5. An illness, injury, impairment or physical or mental condition that involves multiple treatments for restorative surgery or for a condition such as chemotherapy for cancer that, if not treated, would likely result in incapacity of more than three days. OAR 839-009-0210(20)(g)	5. Conditions that require multiple treatments for restorative surgery or would likely result in a period of incapacity for more than three calendar days without medical treatment, e.g. cancer chemotherapy, severe arthritis (physical therapy). 29 CFR §825.115(e)
6. Any period of disability due to pregnancy or period of absence for prenatal care. ORS 659A.150(6)(c), OAR 839-009-0210(20)(h)	6. Pregnancy, including prenatal and postnatal care. 29 CFR §825.115(b)
"Covered service member" leave is not covered by OFLA.	An injury or illness incurred by a covered service member in the line of duty on active duty that may render the service member unfit to perform the duties of the member's office, grace, rank, or rating. 29 CFR §825.127
A "health care provider" is a person who is primarily responsible for providing health care to an eligible employee or a family member of an eligible employee, who is performing within the scope of the person's professional license or certificate, and who is: • a physician, including a doctor of osteopathy, • a podiatrist, dentist, psychologist, optometrist, naturopath, registered nurse, nurse practitioner, direct entry midwife, licensed registered nurse who is certified as a nurse midwife nurse practitioner, clinical social worker, or chiropractor; • a person who is primarily responsible for the treatment of an eligible employee or a family member of an eligible employee solely through spiritual means, including but not limited to a Christian Science practitioner. ORS 659A.150(5), OAR 839-009-0210(14)	A "health care provider" is: • a licensed doctor of medicine or osteopathy; • a licensed podiatrist, dentist, clinical psychologist, optometrist, or chiropractor performing within the scope of their practice; • a licensed nurse practitioner, nurse-midwife, clinical social worker, or physician assistant performing within the scope of their practice; • a Christian Science Practitioner; • any health care provider from whom an employer or the employer's group health plan's benefits manager will accept certification of the existence of a serious health condition to substantiate a claim for benefits; and • a health care provider listed above who practices in another country who is authorized to practice in that country and is performing within the scope of their practice. 29 CFR §825.125