MEDICAL LEAVE
Leave to care for one’s own serious health condition.

CHECKLIST

Do NOT give the entire leave packet to your health care provider. Separate the forms from the back of the packet to use at the appropriate time. Submit all forms directly to the Leaves of Absence coordinator.

1. **Read the Detailed Leave Instructions** - on the following pages

2. **Leave of Absence Request**
   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 Leaves of Absence coordinator.

3. **Employee Medical Certification**
   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 Leaves of Absence coordinator for medical confidentiality.

4. **FMLA/OFLA Leave Tracking Calendar** (Intermittent Leaves Only)
   Only to be used with Intermittent Leaves.
   Track all absences related to your approved leave.
   Submit completed calendar to the Leaves of Absence coordinator on the last contract day of each month.

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. **Notify the District of any changes to your leave dates & confirm your return date**
   Advise your administrator/supervisor and the Leaves of Absence Coordinator by phone or email.
   Provide additional medical certification.

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Leave Related Contacts and Resources

**Leaves of Absence:**
- Phone: 541-790-7689
- Email: 4j_leaves@4j.lane.edu
- Confidential fax: 541-790-7680
- Website: http://www.4j.lane.edu/hr/loa/

**Employee Benefits:**
- Phone: (541) 790-7675
- Fax: (541) 790-7665
- Email: 4j_benefits@4j.lane.edu
- Website: http://www.4j.lane.edu/hr/benefits/

**Aesop:**
- Website: http://www.aesopeducation.com/

**Human Resources:**
- Address: 200 N Monroe St, Eugene, OR 97401
- Phone: (541) 790-7660
- Email: hr@4j.lane.edu
- Website: http://www.4j.lane.edu/hr/
# MEDICAL LEAVE INSTRUCTIONS

Submit all documents to the Leaves of Absence coordinator:
Confidential Fax: (541) 790-7680
Phone: (541) 790-7689
Email: 4j_leaves@4j.lane.edu

<table>
<thead>
<tr>
<th>DOCUMENTS:</th>
<th>The <strong>Medical Leave Packet</strong> contains the necessary forms. Send all documents to the Leaves of Absence coordinator.</th>
</tr>
</thead>
<tbody>
<tr>
<td>REQUEST LEAVE:</td>
<td>Complete the <strong>Leave of Absence Request Form</strong> as soon as your need for leave is known, with 30 days prior notice when possible.</td>
</tr>
<tr>
<td>MEDICAL CERTIFICATION:</td>
<td>You must use the <strong>Employee Medical Certification</strong> 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 Leaves of Absence coordinator for medical confidentiality. 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 Leaves of Absence coordinator.</td>
</tr>
<tr>
<td>REPORTING YOUR ABSENCES:</td>
<td>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.</td>
</tr>
<tr>
<td>REQUESTING LEAVE EXTENSIONS:</td>
<td>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. <strong>Additional Unpaid Leave:</strong> A request to take additional unpaid leave, beyond your FMLA and/or OFLA entitlement, requires the approval of your Administrator. Please submit your email request to them as soon as possible. This will allow appropriate staffing arrangements to be made.</td>
</tr>
<tr>
<td>INTERMITTENT LEAVE:</td>
<td>In addition to your normal absence reporting procedures: <strong>Scheduled absences:</strong> 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. <strong>Unexpected absences:</strong> 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. <strong>Changes to your leave:</strong> 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.</td>
</tr>
<tr>
<td>RETURN TO WORK:</td>
<td>Following a surgery or absence of five or more days, a full medical release is required at least one business day prior to your return. Your return will be delayed until a medical release is provided. Please provide your medical release to the Leaves of Absence coordinator for approval at FAX: (541) 790-7680.</td>
</tr>
<tr>
<td>USE OF PAID LEAVE:</td>
<td>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.</td>
</tr>
<tr>
<td>BENEFITS WHILE ON LEAVE:</td>
<td>Your District-paid benefits will continue if you are in a paid status (i.e. sick leave) or on approved leave under FMLA/OFLA. <strong>Unpaid Medical Leave:</strong> While you are on an approved unpaid medical leave, you may be eligible to continue the District health insurance plan with the District contribution (some restrictions apply) as long as you continue your employee contribution. For more information see the EEA contract section 9.1, the OSEA contract section 14.2, or the 4JA statement of understanding section 8.B.4.</td>
</tr>
<tr>
<td>OTHER:</td>
<td>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.</td>
</tr>
</tbody>
</table>
A. PERSONAL INFORMATION
☐ Classified ☐ Licensed ☐ Administrator

Name: ___________________________ Employee ID: ___________________________
Preferred email: ___________________ ☐ Check if you would prefer correspondence via US Mail (using address on file)

Job Title: ___________________________ Home Phone: (____) _______ - _______ Cell Phone: (____) _______ - _______
Administrator/Supervisor: ___________________________ Work Location: ___________________________
Month/Year of Hire: ___________________________ Current FTE/Hours per Week: ___________________________

Does your ☐ spouse / ☐ same-sex domestic partner also work for the district? ☐ Yes ☐ No Employee Name: ___________________________
Will he/she be requesting leave for the same reason (e.g. parental, to care for you or an ill family member)? ☐ Yes ☐ No

B. REASON FOR LEAVE REQUEST

☐ Medical Leave (Due to employee’s own serious health condition or pregnancy disability)
☐ Family Medical Leave (Due to immediate family member’s serious health condition)

Family Member Name: ___________________________
Relationship: ☐ Spouse ☐ Son/Daughter ☐ Parent ☐ Parent-in-law ☐ Grandparent ☐ Grandchild ☐ Same-Gender Domestic Partner
☐ Sibling ☐ Other: ___________________________

☐ Parental Leave for: ☐ Birth of my child ☐ Adoption of a child ☐ Placement of a foster child
Anticipated date of birth, adoption, or placement: ___________________________

☐ Bereavement Leave
Family Member Name: ___________________________
Relationship: ☐ Spouse ☐ Son/Daughter ☐ Parent ☐ Parent-in-law ☐ Grandparent ☐ Grandchild ☐ Same-Gender Domestic Partner
☐ Sibling ☐ Other: ___________________________

☐ Additional Leaves
☐ Military Leave (Due to be called to active duty) ☐ Military Leave (Due to family member being deployed or on leave from service)
☐ Personal Leave (Outline details in Section D) ☐ Professional Leave (Outline details in Section D)
☐ Part-Time Leave (Licensed and Administrators only) Working: ___________________________ FTE
☐ Association Leave (Licensed only)

C. ABSENCE REQUEST – Check all that apply (estimated dates must be entered)

☐ FULL SCHEDULE LEAVE From ________________ Through ________________ Returning ________________

☐ REDUCED SCHEDULE From ________________ Through ________________ Returning ________________

Describe requested schedule: ___________________________

☐ INTERMITTENT (not for parental leave) From ________________ Through ________________

For intermittent, complete the following in full – do not leave blank or answer unknown.

☐ Medical treatment for myself or an immediate family member

☐ Episodes of chronic illness which result in: ☐ My inability to work ☐ My family member’s inability to perform activities of daily living

Estimated frequency of absences: ___________________________
Estimated length of each absence: ___________________________

Rev June 30, 2014 Leave of Absence Request Form 1 of 2
D. ADDITIONAL COMMENTS – Attach additional sheet if necessary


E. EMPLOYEE SIGNATURE – Read the following rights and responsibilities carefully before signing.

- I understand that I am required to provide supporting documentation, medical or otherwise, directly to the Leaves of Absence coordinator, within 15 days of this request or before my leave begins, whichever is later. I understand that failure to provide adequate and timely certification will disqualify my leave from job protection under the Federal Family Medical Leave Act (FMLA) and the Oregon Family Leave Act (OFLA) statutes and that my leave will be denied in accordance with § 825.305 and 839-009-0250.
- I understand that I am responsible for ensuring my absences are reported according to my department and District policy. I will check with my Supervisor/Administrator if I am uncertain of my responsibilities or need assistance reporting my absences while on leave.
- I understand that if I do not return to work, I may be requested to reimburse the District for any District-paid group health insurance that I was provided while on the unpaid portion of my leave of absence unless my failure to return to work is due to a continuation or reoccurrence of a serious health condition or other circumstances as permissible by Federal and State law.
- I certify that the information provided on this form is accurate and correct.
- I have reviewed the appropriate checklist and instructions for the leave type requested: [http://www.4j.lane.edu/hr/loa](http://www.4j.lane.edu/hr/loa)

<table>
<thead>
<tr>
<th>Employee Signature</th>
<th>Date (mm/dd/yyyy)</th>
</tr>
</thead>
</table>

F. SUPERVISOR/ADMINISTRATOR – Please email or fax this form to the Leaves of Absence coordinator within 24 hours.

- My signature indicates that I have reviewed the leave with this employee.
- I have explained the expectations for absence reporting and arranging a substitute, if applicable.
- I have directed him/her to forward required documentation directly to the Leaves of Absence coordinator.

<table>
<thead>
<tr>
<th>Administrator/Supervisor (Print Name)</th>
<th>Signature</th>
<th>Date (mm/dd/yyyy)</th>
</tr>
</thead>
</table>
Complete Part 1 and ask your healthcare professional to complete Part 2. Return/fax this form to the Leaves of Absence coordinator. It is your responsibility to ensure that the Leaves of Absence coordinator receives this completed form prior to your leave or within 15 days of the beginning of your leave in order to determine if your absence qualifies as a serious health condition under the Family Medical Leave Act (FMLA) or the Oregon Family Leave Act (OFLA). If timely medical documentation is not received, your leave may be denied and subject to the District’s attendance policy.

PART 1: EMPLOYEE

Name: _____________________________ Employee ID: __________ Date of Birth: __/__/____

Phone: (___) ___ Cell: (____) ___ Home email: _____________________________

Job Title: __________________________ I have attached my job description? ☐Yes ☐No

Describe your Essential Job Functions:

Employee’s Consent to Release Medical Information

In order to expedite the process, I _______ DO / _______ DO NOT (initial one) voluntarily give my permission to my medical provider to forward this medical certification directly to Leaves of Absence, who will maintain my medical information confidentially and separate from my personnel file. I understand that it is my responsibility to ensure that medical certification is received by Leaves of Absence.

________________________________________________________________________

EMPLOYEE SIGNATURE DATE

PART 2: HEALTHCARE PROVIDER – Please complete in full, using additional paper if necessary.

Medical Facts

1. Approximate date condition commenced? __/__/____

   Probable duration of condition ________ days or ________ weeks or ________ months or ________ years

   Was patient admitted for an overnight stay in hospital, hospice, or residential facility? ☐Yes ☐No

   If yes, date of admission: __/__/____ Date of discharge: __/__/____

   Dates you treated the patient for the condition: _____________________________

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

   Was the patient referred to other healthcare providers for evaluation or treatment? ☐Yes ☐No

   If yes, state the nature and expected duration of such treatments:

   _____________________________

   _____________________________

2. Is the medical condition pregnancy? ☐Yes ☐No (Please also answer, 1, 3-7) Expected delivery date: __/__/____

   Is this a surgical delivery? ☐Yes ☐No Are there medical complications? ☐Yes ☐No

3. Answer this based upon the employee’s essential job functions or the employee’s description of his/her job functions.

   Due to the medical condition, the employee is unable to perform his/her job function: ☐CORRECT ☐INCORRECT

   Identify the job functions the employee is unable to perform (lifting more than 20#, squatting, etc.):

   _____________________________

4. Describe the medical facts related to the condition for which the patient needs care such as symptoms, diagnosis, or any regimen of continuing treatment such as the use of specialized equipment:

   _____________________________

   _____________________________

Rev June 30, 2014 Medical Certification - Employee 1 of 2
### Continuous Care

5. Will the employee be incapacitated for a single continuous period of time, including time for treatment and recovery? ☐ Yes ☐ No
   
   Estimated BEGINNING date: __/__/_______  Estimated ENDING date: __/__/_______

### Part-time or Intermittent Care (#6 - #7 must be completed)

- Several questions seek a response as to the frequency or duration of a condition, treatment, etc. Be as specific as you can.
- Your answer should be your best estimate based on your medical knowledge, experience, and examination of the patient.
- Terms such as "lifetime", "unknown", or "indeterminate" may not be sufficient to determine FMLA coverage.

6. Will the employee need to attend follow-up treatments because of the medical condition? ☐ Yes ☐ No
   
   If yes, are the treatments medically necessary? ☐ Yes ☐ No
   
   Estimate the treatment schedule, if any, including the dates of any scheduled appointments and the time required for each appointment, including any recovery period:

   ______________________________________________________
   ______________________________________________________
   ______________________________________________________
   ______________________________________________________
   ______________________________________________________
   ______________________________________________________

   Will the employee need to work a reduced schedule basis because of his/her medical condition? ☐ Yes ☐ No
   
   If yes, is the reduced number of hours of work medically necessary? ☐ Yes ☐ No
   
   Estimate the reduced work schedule the employee can work, if any:

   _________ hour(s) per day  _________ days per week  from__/__/____ through __/__/____

7. Will the condition cause episodic flare-ups periodically preventing the participation in normal daily activities? ☐ Yes ☐ No
   
   If yes, please explain:

   ______________________________________________________
   ______________________________________________________
   ______________________________________________________
   ______________________________________________________
   ______________________________________________________
   ______________________________________________________

   Estimate the frequency of flare-ups and the duration of each related incapacity expected over the next 6 months (based upon the patient's medical history and your knowledge of the medical condition).

   Frequency: ____________ times per ☐ Week, or ☐ Month, or ☐ Year, or ☐ Other: ____________
   
   Duration per episode: ____________ hour(s), or ____________ day(s), or ____________ week(s)
   
   How long will these episodes continue?

   ______________________________________________________
   ______________________________________________________
   ______________________________________________________
   ______________________________________________________
   ______________________________________________________

### Additional Comments:

____________________________________________________________________________________
____________________________________________________________________________________
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### Contact Information and Signature

Healthcare Provider Name: _____________________________________________________________ License number: _____________________________

Specialty/Type of Practice: ___________________________________________________________

Phone: (____) - ________  Fax: (____) - ________  Email: _________________________________

_________________________________________________________________________________

Healthcare Provider Signature  Date (mm/dd/yyyy)
FMLA/OFLA Leave Tracking Calendar

Submit a copy of this completed calendar on the last contract day of each month.
Interoffice mail: Leaves of Absence coordinator in Human Resources, Email: 4j_leaves@4j.lane.edu, Fax: 541-790-7680

<table>
<thead>
<tr>
<th>School Year:</th>
<th>Employee name:</th>
<th>ID:</th>
</tr>
</thead>
<tbody>
<tr>
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<thead>
<tr>
<th>Job Title:</th>
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<tr>
<th>Department:</th>
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</table>

Expected frequency/duration of FMLA/OFLA Absences, based on ☐ Medical Certification ☒ Self-report

The maximum time off cannot exceed that which is medically certified as necessary.
Updated medical certification is generally required every six months, or sooner, if the frequency or duration of your need to be absent changes.
You must advise your Administrator (or designee) of each absence that is due to your FMLA/OFLA leave no later than the day you return to work.

TRACKING: Enter the number of hours per day absent due to your FMLA/OFLA qualifying reason.
(If doesn't matter if, or how, your absence is paid.)

| Month      | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | 11 | 12 | 13 | 14 | 15 | 16 | 17 | 18 | 19 | 20 | 21 | 22 | 23 | 24 | 25 | 26 | 27 | 28 | 29 | 30 | 31 | Hours Used |
|------------|---|---|---|---|---|---|---|---|---|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|---|----------|
| July       |   |   |   |   |   |   |   |   |   |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    | 0.00     |
| August     |   |   |   |   |   |   |   |   |   |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |          |
| September  |   |   |   |   |   |   |   |   |   |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |          |
| October    |   |   |   |   |   |   |   |   |   |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |          |
| November   |   |   |   |   |   |   |   |   |   |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |          |
| December   |   |   |   |   |   |   |   |   |   |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |          |
| January    |   |   |   |   |   |   |   |   |   |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |          |
| February   |   |   |   |   |   |   |   |   |   |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |          |
| March      |   |   |   |   |   |   |   |   |   |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |          |
| April      |   |   |   |   |   |   |   |   |   |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |          |
| May        |   |   |   |   |   |   |   |   |   |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |          |
| June       |   |   |   |   |   |   |   |   |   |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |          |

Total Hours Used: 0.00