NON-MEDICAL LEAVE
All leave types not pertaining to medical necessity.

CHECKLIST

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
   Obtain Supervisor/Administrator signature and forward to the Leaves of Absence coordinator.

_____ 3. Report your absences
   You are required to follow normal absence reporting procedures.

_____ 4. 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.

Leave Related Contacts and Resources

Leaves of Absence: Phone: 541-790-7689  Confidential fax: 541-790-7680
   Email: 4j_leaves@4j.lane.edu  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/
## NON-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 Non-Medical Leave Packet 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 Leave of Absence Request Form as soon as your need for leave is known, with 30 days prior notice when possible.</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.</td>
</tr>
<tr>
<td>RETURN TO WORK:</td>
<td>Please contact your administrator and the Leaves of Absence coordinator by email the week prior to your return to confirm your return date.</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.</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: ___________________________
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

Employee Signature

Date (mm/dd/yyyy)

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.

Administrator/Supervisor (Print Name)

Signature

Date (mm/dd/yyyy)