FAMILY LEAVE

Leave to care for your newborn child, to care for your newly adopted child, to provide foster care, or to care for an immediate family member who has a serious health condition.

C H E C K L I S T

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. *Family Member 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 family leave, sick leave, personal leave, and vacation, if applicable, prior to taking unpaid leave.

_____**6. Add your child to your group health insurance plan within 60 days of birth/placement**
See Midyear Change Form at: https://www.4j.lane.edu/hr/benefits/life-events/covering-your-dependents/
Submit to Human Resources when completed.

_____**7. 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.

Leave Related Contacts and Resources

Leaves of Absence: Phone: 541-790-7676 Confidential fax: 541-790-7680
Email: HR_leaves@4j.lane.edu Website: http://www.4j.lane.edu/hr/loa/

Employee Benefits: Phone: (541) 790-7681 Fax: (541) 790-7665
Email: HR_benefits@4j.lane.edu Website: http://www.4j.lane.edu/hr/benefits/

Absence Management: Website: http://www.aesopeducation.com/
Email: HR_subdesk@4j.lane.edu
Phone: (541) 790-7689

Human Resources: Address: 200 N Monroe St, Eugene, OR 97401 Phone: (541) 790-7670
Email: hr@4j.lane.edu Website: http://www.4j.lane.edu/hr/

FAMILY LEAVE INSTRUCTIONS

Submit all documents to the Leaves of Absence coordinator:
Confidential Fax: (541) 790-7680 Phone: (541) 790-7676 Email: HR_leaves@4j.lane.edu

DOCUMENTS: The ***Family Leave Packet*** contains the necessary forms. Send all documents to the Leaves of Absence coordinator.

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

MEDICAL CERTIFICATION: You must use the ***Family Member Medical Certification*** 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.

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

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

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

RETURN TO WORK: Please contact your administrator and the Leaves of Absence coordinator 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 family leave, sick leave, personal leave, vacation, compensatory, discretionary, 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.

Eugene School District
200 N Monroe St, Eugene, OR 97402
Email: HR_leaves@4j.lane.edu
Fax: (541) 790-7680

Leave of Absence Request Form

Please refer to appropriate checklist for additional information

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: _____

If you have a ☐ spouse / ☐ same-sex domestic partner, do they 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:_____ Date of Death: _____

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 unless I am on an intermittent leave, that HR will document my paid leave while I am on an approved 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) _____

Eugene School District
200 N Monroe St, Eugene, OR 97402
Email: HR_leaves@4j.lane.edu
Fax: (541) 790-7680

Family Member Medical Certification

Please refer to appropriate checklist for additional information

Complete Part 1 and ask your family member's healthcare professional to complete Part 2. Return/fax this form to the Leaves of Absence coordinator. It is your responsibility to insure 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:

Family Member Name:_____ City, State of Residence:

Relationship: ☐Spouse ☐Son/Daughter ☐Parent
☐Parent-in-law ☐Grandparent ☐Grandchild ☐Same-Gender Domestic Partner
☐Sibling ☐Other:_____

Will you need to take family leave intermittently? ☐Yes ☐No

If yes, **describe estimated schedule of absences**:_____

Describe the medically necessary care you will be providing for your family member:_____

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 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:_____

Continuous Care

4 Will the patient be incapacitated for a single continuous period of time, including time for treatment and recovery? ☐Yes ☐No

Estimated BEGINNING date: ___/___/_____ Estimated ENDING date: ___/___/_____

During this time, will the patient need care? ☐Yes ☐No

Explain the care needed by the patient and why such care is medically necessary:_____

_____

_____

_____

_____

Part-time or Intermittent Care *(#5 - #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.

5 Will the patient need to attend follow-up treatments, including any time for recovery? ☐Yes ☐No

If yes, estimate the treatment schedule, if any, including the dates of any scheduled appointments and the time required for each appointment, including any recovery period:_____

_____

_____

_____

_____

6 Will the patient require care on an intermittent or reduced schedule basis, including time for recovery? ☐Yes ☐No

_____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)

Does the patient need care during these flare-ups? ☐Yes ☐No

How long will these episodes continue?_____

Explain the care needed by the patient and why such care is medically necessary:_____

_____

_____

_____

_____

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

School Year: _____ **Employee name:** _____ **ID:** _____
Job Title: _____
Department: _____

Expected frequency/duration of FMLA/OFLA Absences, based on ____ Medical Certification ___x___ 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.
(It 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																																
August																																
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Total Hours Used: 0.00