FAMILY AND MEDICAL LEAVE REQUEST FORM

CONFIDENTIAL INFORMATION

EMPLOYEE INFORMATION	
NAME	EMPLOYEE ID
DIVISION	DEPARTMENT
POSITION	SUPERVISOR
WORK PHONE	DATE HIRED
ALTERNATE CONTACT PHONE	WEEKLY WORK SCHEDULE and HOURS PER WEEK

REASON FOR REQUESTED LEAVE

❑ Care for newborn, adopted or foster child ('parental leave')

❑ Care for my own serious health condition

❑ Care for a family member with a serious health condition. Specify relationship ______________________________
If the family member is your child, is the child under the age of 18? ❑Yes ❑No

❑ Pregnancy related disability – Female Employees Only. (includes routine pre-natal care)

❑ Bereavement Leave (OFLA only)

❑ Other: (please see the reverse side of this form for qualifying leaves) ______________________________________

DATES OF LEAVE: FROM: ______________________________ TO: ____

Are you requesting leave on an intermittent schedule (reduced hours per day or days per week)? ❑Yes ❑No

EMPLOYEE ACKNOWLEDGEMENT

- I understand that my leave will preliminarily be designated as leave protected under the Family and Medical Leave Act (FMLA) and Oregon Family Leave Act (OFLA) and if approved; my leave will be counted against my annual FMLA and OFLA leave entitlement.
- MY FMLA/OFLA leave is **CONDITIONALLY** granted as of the beginning date of my leave. Prior to Human Resources designating my leave as qualifying, I must have my or my family member's medical provider complete the '*Certification of Health Care Provider'* and I must return the completed form to Human Resources **within 15 calendar days** of this notification. Failure to return the completed form in a timely manner may delay my leave designation
- If my leave is for my own serious health condition, I understand that prior to returning to work, I may be required to provide a release to work from a health care provider
- If using leave on an intermittent basis, I understand that it will be my responsibility to notify my supervisor when absences are due to FML reasons
- I understand that I will not be eligible to accrue vacation, sick leave or seniority if my leave becomes unpaid and results in unqualified pay periods as defined by Washington County's Personnel Rules and Regulations
- When the medical certification is unclear, or its validity is in doubt, the County may require me or my family member to obtain a second or third opinion at the County's expense.

Employee's Signature____**Date**____________________

Supervisor please complete reverse side of form

NAME:	EMPLOYEE ID

QUALIFYING LEAVES

- For the birth and care of the newborn child of the employee (‘parental leave’)
- For the placement of a child for adoption or foster care with the employee (parental leave)
- To provide immediate and necessary care for the employee’s own parent (including individuals who exercise parental responsibility under state law), child, or spouse with a serious health condition
- For the employee’s own serious health condition
- Caregiver Leave for injured service member
- Family Leave Due to a call to active duty
- Leave for victims of domestic violence, sexual assault or stalking
- Bereavement leave (up to 2 weeks per covered family member)

REQUESTED USE OF ACCRUED PAID LEAVE

Employees on a medical leave of absence to care for themselves or a qualified family member are required to use all accrued sick leave prior to using other accrued paid leave or being placed on leave without pay. Use of all accrued sick leave is also required to meet eligibility for disability payments. If you are applying for ‘parental leave’ please refer to the designation notice that will be sent by Human Resources once your leave is approved.

SUPERVISOR ACKNOWLEDGEMENT

I have reviewed this request and acknowledge the leave requiring time away from his/her position. I understand Washington County Human Resources retains full authority in determining whether this request meets eligibility requirements under the Family and Medical Leave Act or the Oregon Family Medical Leave Act.

Supervisor’s Signature: ____ Date_______________

Commander's Signature:(*Sheriff’s Office only*) _____________________________________ Date_______________

Appointing Authority’s Signature: _____________________________________ Date_______________

THIS FORM MUST BE FORWARDED TO THE HUMAN RESOURCES DIVISION WITH IN 3 DAYS OF RECEIPT.

EMPLOYEE MEDICAL INFORMATION MAY NOT BE REPRODUCED OR RETAINED IN ANY MANNER BY THE EMPLOYEE’S DEPARTMENT. ALL INFORMATION CONTAINED ON THIS FORM SHALL REMAIN CONFIDENTIAL.

A COPY OF THIS FORM ONLY MAY BE RETAINED BY THE DEPARTMENT TO ASSIST IN SCHEDULING LEAVE. THE ORIGINAL WILL BE RETAINED IN THE EMPLOYEE’S MEDICAL LEAVE FILE IN HUMAN RESOURCES.

Human Resources Use Only

❑ OFLA ❑ FMLA ❑ Both

❑ Non OFLA/FMLA (explanation below):

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Human Resources Analyst ____ Date_______________