OFLA/FMLA LEAVE REQUEST FORM

Complete the form and save a printed copy for your files. The form can be faxed to Human Resources at (503)353-7378 or emailed to hrinfo@nclack.k12.or.us. Contact HR at (503) 353-6000 with any questions.

Name: _____ Employee#: _____ ○ Administrator ○ Classified ○ Licensed ○ Confidential

Hire Date: _____ FTE/Hours per week: _____ School/Location: _____ Supervisor: _____

TYPE OF LEAVE AND REQUESTED DATES: ○ Not Working At All ○ Intermittent Leave (working with occasional time off)

Date Leave Begins: _____ Date Leave Ends: _____ First Day Back At Work: _____

- If you are unclear about when you are returning, please explain in comment box below:

Comment:

You must have the Certification of Health Care Provider completed by a physician or health care provider and submit it to Human Resources no later than *30 days prior* to the anticipated leave start or *15 days after* an emergency/unplanned leave.

REASON FOR LEAVE: **Please choose one reason for leave**

○ ***SERIOUS HEALTH CONDITION:***

○ Employee **Is this serious health condition a result of an on the job injury ○ YES ○ NO**

○ Family Member Name of Family Member: _____

Relationship:

○ Spouse ○ Same-sex domestic partner

○ Parent (biological/step/in-law) ○ Parent of same-sex domestic partner

○ Child of same-sex partner ○ Grandchild ○ Grandparent

○ Child (biological/adopted/step/foster/legal ward/in loco parentis)

○ Bereavement (OFLA) Name of Family Member: _____ Date of Death: _____

Relationship: **(You must choose one relationship from the family member list)** _____

○ ***PARENTAL:***

○ Childbirth/Pregnancy: Expected date of delivery: _____

○ Newborn child bonding: Birth date of child: _____

○ Adoption /Foster Care*: Placement date: _____

*submit copy of adoption application/foster care papers with this application.

○ ***If your spouse or same-sex domestic partner works for the NCSD & they will be taking leave to care for you or the same child, check this box and have them complete the OFLA/FMLA application.***

Name: _____ Employee Number: _____ School: _____

Date Leave Begins: _____ Date Leave Ends: _____ First Day Back At Work: _____

○ ***SICK CHILD:***

Describe illness:

○ ***MILITARY:***

○ Serious Injury to Active Service Member: ○ Spouse ○ Child ○ Parent ○ Next of Kin

Describe Injury:

○ Exigency of Active Service Member: ○ Spouse ○ Child ○ Parent ○ Next of Kin

○ Rest and Recuperation ○ Short-term Notice of Deployment ○ Regular Deployment

Submitting this form confirms the accuracy of the information provided above and that you have received and understand the North Clackamas School District's OFLA/FMLA policy.

Employee Signature: _____ **Date:** _____

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North Clackamas Schools

North Clackamas School District

INSTRUCTIONS for Health Care Provider: Return this form to the patient or fax (marked CONFIDENTIAL) to the attention of: **(503)353-7378** fax or emailed to **hrinfo@nclack.k12.or.us**

INSTRUCTIONS for the Employee: This form must be completed by a physician or other health care provider. Return it to **North Clackamas School District** at the address or fax number listed above ***within 15 days*** from the request for medical certification.

Federal and Oregon Family Medical Leave

Health Care Provider Certificate of Serious Health Condition

This form relates only to the condition for which the emp loyee is taking leave.

Employee's Name: _____

Patient's Name (if different from employee)**:** _____

1. Relationship to employee:

☐ Child (17 years or younger) ☐ Child (18 years or older) ☐ Spouse
☐ Parent (includes adoptive or in loco parentis) ☐ Parent-in-law
☐ Same gender domestic partner/partner's parent/partner's child ☐ Grandparent/Grandchild

2. Nature of "serious health condition" (see reverse side for definitions): Please check the appropriate category or categories:

☐ 1-Hospital care ☐ 4-Chronic condition requiring treatment
☐ 2-Absence plus treatment ☐ 5-Perm/long-term condition requiring supervision
☐ 3-Pregnancy or prenatal care ☐ 6-Multiple treatments (non-chronic condition)

Provide a description of the medical facts that support your certification and explain how they meet the criteria of the category:

_____
_____

2. Approximate date patient's condition began: _____/_____/_____

3. If this is a chronic condition or pregnancy, is the patient presently incapacitated? (see reverse side for definition) ☐ No ☐ Yes, duration and frequency of episodes of incapacity: _____

4. Will it be necessary for the ***employee*** to take:

a. **Full-time leave**
☐ No ☐ Yes If Yes: Effective dates: From _____/_____/____ to ____/____/____.

b. **Leave intermittently** or to work on a less than full-time schedule due to this serious health condition
☐ No ☐ Yes If Yes: Effective dates: From ___/___/_____ to ___/___/_____

Frequency: ☐ One - two days/month ☐ Two - three days/month ☐ Three - four days/month
☐ Other: Please explain how the employee will use leave intermittently, being as specific as possible including frequency and duration of absences. _____
_____

c. **Reduced Schedule**: _____

5. If the patient requires a regimen of treatment, what is the nature of and description of the treatments, an estimated number of treatments and intervals between treatments? (see reverse side for definition)_____
What are the actual or estimated dates of visits for treatment, or frequency of visits for treatment?
_____

6. If this certification relates to the employee's seriously ill family member(s), also complete the following:

a. Does the patient require assistance for basic medical or personal needs or safety, or for transportation? ☐Yes ☐No
b. If no, would the employee's presence to provide psychological comfort be beneficial or assist in the patient's recovery? ☐ Yes ☐ No
c. If the patient will need care only intermittently or on a part-time basis, please indicate the probable duration and frequency of this need. _____

_____ _____
Printed Name of Physician/Practitioner *Date signed*

_____ _____
Signature of Physician/Practitioner *Type of Practice/Field of Specialization*

_____
Phone Number

HEALTH CARE PROVIDER

Caution: Per the Genetic Information Nondiscrimination Act of 2008 (GNA) this agency is **not** requesting or requiring genetic information of its employees or their family members. We ask that you not provide any genetic information when responding to this request for medical information.

Definition of a "Serious Health Condition": an illness, impairment, physical or mental condition that involves one of the following situations:

1. **Hospital care.** Inpatient care (i.e., overnight stay) in a hospital, hospice, or residential medical care facility, including any period of incapacity or subsequent treatment in connection with or consequent to such inpatient care.

2. **Absence plus treatment.** A period of incapacity of more than three consecutive calendar days (including any period of incapacity or subsequent treatment relating to the same condition), that also involves:

   (a) Treatments two or more times by a licensed healthcare provider, nurse, or physician's assistant under direct supervision of a healthcare provider, or by a provider of healthcare services (e.g., physical therapist) under orders of, or on referral by, a healthcare provider ***or***

   (b) Treatment by a healthcare provider on at least one occasion which results in a regimen of continuing treatment under supervision of the healthcare provider.

      (1) Treatment includes examinations to determine if a serious health condition exists and evaluations of the condition. Treatment DOES NOT include routine physical, dental, or eye examinations.

      (2) A regimen of continuing treatment includes, for example, a course of prescription medication (e.g., an antibiotic) or therapy requiring special equipment to resolve or alleviate the health condition. A regimen of treatment DOES NOT include the taking of over-the-counter medications such as aspirin, antihistamines, or salves; or bed-rest, drinking fluids, exercise, or any other similar activities that can be initiated without a visit to a healthcare provider.

3. **Pregnancy.** Any period of incapacity due to pregnancy, pregnancy-related illness, or for prenatal care.

4. **Chronic conditions requiring treatments.** A chronic serious health condition is one which:
   a) Requires periodic visits for treatment by a healthcare provider, nurse, or physician's assistant under direct supervision of a healthcare provider;
   b) Continues over an extended period of time (including recurring episodes of a single underlying condition); and
   c) May cause episodic rather than continuing periods of incapacity (e.g., asthma, diabetes, epilepsy, etc.)

5. **Permanent or long-term conditions requiring supervision.** A period of incapacity that is permanent or long-term due to a condition for which treatment may not be effective. The employee or family member must be under the continuing supervision of, but need not be receiving active treatment by, a healthcare provider. Examples include Alzheimer's, a severe stroke or the terminal states of a disease.

6. **Multiple treatments (non-chronic conditions).** Any period of absence to receive multiple treatments (including any period of recovery) by a healthcare provider or by a provider of healthcare services under orders of, or on referral by, a healthcare provider, either of restorative surgery after an accident or other injury, or for a condition that would likely result in a period of incapacity of more than three consecutive calendar days in the absence of medical intervention or treatment, such as cancer (chemotherapy, radiation, etc.), severe arthritis (physical therapy), kidney disease (dialysis).

Definition of "Incapacitated": Inability to work, attend school, or perform other regular daily activities due to the serious health condition, treatment, or recovery.

Directions regarding "Regimen of treatment" (question 5): If the patient is under your supervision, provide a general description of such regimen, such as prescription drugs, physical therapy requiring special equipment. If the treatments will be provided by another provider of health services, such as a physical therapist, please state the nature of the treatments.