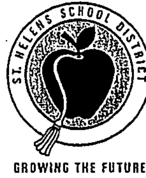

EMPLOYEE RIGHTS AND RESPONSIBILITIES UNDER THE FAMILY AND MEDICAL LEAVE ACT

Basic Leave Entitlement
FMLA requires covered employers to provide up to 12 weeks of unpaid, job-protected leave to eligible employees for the following reasons:
- For incapacity due to pregnancy, prenatal medical care or child birth;
- To care for the employee's child after birth, or placement for adoption or foster care;
- To care for the employee's spouse, son or daughter, or parent, who has a serious health condition; or
- For a serious health condition that makes the employee unable to perform the employee's job.

Military Family Leave Entitlements
Eligible employees with a spouse, son, daughter, or parent on active duty or call to active duty status in the National Guard or Reserves in support of a contingency operation may use their 12-week leave entitlement to address certain qualifying exigencies. Qualifying exigencies may include attending certain military events, arranging for alternative childcare, addressing certain financial and legal arrangements, attending certain counseling sessions, and attending post-deployment reintegration briefings.

FMLA also includes a special leave entitlement that permits eligible employees to take up to 26 weeks of leave to care for a covered servicemember during a single 12-month period. A covered servicemember is a current member of the Armed Forces, including a member of the National Guard or Reserves, who has a serious injury or illness incurred in the line of duty on active duty that may render the servicemember medically unfit to perform his or her duties for which the servicemember is undergoing medical treatment, recuperation, or therapy; or is in outpatient status; or is on the temporary disability retired list.

Benefits and Protections
During FMLA leave, the employer must maintain the employee's health coverage under any "group health plan" on the same terms as if the employee had continued to work. Upon return from FMLA leave, most employees must be restored to their original or equivalent positions with equivalent pay, benefits, and other employment terms.

Use of FMLA leave cannot result in the loss of any employment benefit that accrued prior to the start of an employee's leave.

Eligibility Requirements
Employees are eligible if they have worked for a covered employer for at least one year, for 1,250 hours over the previous 12 months, and if at least 50 employees are employed by the employer within 75 miles.

Definition of Serious Health Condition
A serious health condition is an illness, injury, impairment, or physical or mental condition that involves either an overnight stay in a medical care facility, or continuing treatment by a health care provider for a condition that either prevents the employee from performing the functions of the employee's job, or prevents the qualified family member from participating in school or other daily activities.

Subject to certain conditions, the continuing treatment requirement may be met by a period of incapacity of more than 3 consecutive calendar days combined with at least two visits to a health care provider or one

visit and a regimen of continuing treatment, or incapacity due to pregnancy, or incapacity due to a chronic condition. Other conditions may meet the definition of continuing treatment.

Use of Leave
An employee does not need to use this leave entitlement in one block. Leave can be taken intermittently or on a reduced leave schedule when medically necessary. Employees must make reasonable efforts to schedule leave for planned medical treatment so as not to unduly disrupt the employer's operations. Leave due to qualifying exigencies may also be taken on an intermittent basis.

Substitution of Paid Leave for Unpaid Leave
Employees may choose or employers may require use of accrued paid leave while taking FMLA leave. In order to use paid leave for FMLA leave, employees must comply with the employer's normal paid leave policies.

Employee Responsibilities
Employees must provide 30 days advance notice of the need to take FMLA leave when the need is foreseeable. When 30 days notice is not possible, the employee must provide notice as soon as practicable and generally must comply with an employer's normal call-in procedures.

Employees must provide sufficient information for the employer to determine if the leave may qualify for FMLA protection and the anticipated timing and duration of the leave. Sufficient information may include that the employee is unable to perform job functions, the family member is unable to perform daily activities, the need for hospitalization or continuing treatment by a health care provider, or circumstances supporting the need for military family leave. Employees also must inform the employer if the requested leave is for a reason for which FMLA leave was previously taken or certified. Employees also may be required to provide a certification and periodic recertification supporting the need for leave.

Employer Responsibilities
Covered employers must inform employees requesting leave whether they are eligible under FMLA. If they are, the notice must specify any additional information required as well as the employees' rights and responsibilities. If they are not eligible, the employer must provide a reason for the ineligibility.

Covered employers must inform employees if leave will be designated as FMLA-protected and the amount of leave counted against the employee's leave entitlement. If the employer determines that the leave is not FMLA-protected, the employer must notify the employee.

Unlawful Acts by Employers
FMLA makes it unlawful for any employer to:
• Interfere with, restrain, or deny the exercise of any right provided under FMLA;
• Discharge or discriminate against any person for opposing any practice made unlawful by FMLA or for involvement in any proceeding under or relating to FMLA.

Enforcement
An employee may file a complaint with the U.S. Department of Labor or may bring a private lawsuit against an employer.

FMLA does not affect any Federal or State law prohibiting discrimination, or supersede any State or local law or collective bargaining agreement which provides greater family or medical leave rights.

FMLA section 109 (29 U.S.C. § 2619) requires FMLA covered employers to post the text of this notice. Regulations 29 C.F.R. § 825.300(a) may require additional disclosures.

Saint Helens
School District 502

Request for Family and Medical Leave Employee Request for Family and Medical Leave (FMLA) and/or Oregon Family Leave (OFLA)

PLEASE PRINT

Where the need for the leave may be anticipated, written request for family and medical leave must be made, if practical, at least 30 days prior to the date the requested leave is to begin. Failure to request leave in a timely manner could result in either the leave being postponed or the amount of leave available reduced up to three weeks.

Name ______________________________ Effective Date of the Leave ______________________

School _____________________________ Title____

Status: ◻ Full Time ◻ Part Time ◻ Temporary

Hire date___________________________ Length of Service__________________________

I request family or medical leave for one or more of the following reasons:*

_____ 1. Because of the birth of my child and in order to care for him or her

Expected date of birth _____________ Actual date of birth ________________
Leave to start ____________________ Expected return date_________________

_____ 2. Because of the placement of a child with me for adoption or foster care
Age of child _______ Date of placement ___________________________
Leave to start __________________ Expected return date __________________

_____ 3. In order to care for a family member[1] with a serious health condition.
Leave to start __________________ Expected return date __________________

Please check one:

Spouse ◻

Domestic Partner (OFLA leave only) ◻

Child (including the biological, adopted or foster child of an employee or a child with whom the employee is or was in a relationship of "in loco parentis") ◻

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[1] "Family member" means the spouse, same-sex domestic partner, custodial parent, noncustodial parent, adoptive parent, foster parent, biological parent, grandparent, parent-in-law, parent of employee's same-sex domestic partner or a person with whom the employee is or was in a relationship of "in loco parentis." It also includes the biological, adopted, grandchild or foster child or stepchild of an employee, child of same-sex domestic partner or a child with whom the employee is or was in a relationship of "in loco parentis."

Parent (biological parent of an employee or an individual who stood "in loco parentis" to an employee when the employee was a child) □

Parent-In-Law (custodial parent, noncustodial parent, adoptive parent, foster parent) **OFLA Leave Only** □

Please state name and address of relation:

Name ___________________________

Address ____

Describe serious health condition____

_____ 4. For a serious health condition which prevents me from performing my job functions. Describe ____

Leave to start _______________ Expected return date _______________

Regarding 3 or 4 above, request intermittent (reduced workday hours) or reduced leave (fewer work days each work week) schedule or alternate duty (if applicable, subject to employer's approval). Please describe schedule of when you anticipate you will be unavailable to work:

____

____

_____ 5. In order to care for a child with a condition requiring home care which does not meet the definition of serious health condition and is not life threatening or terminal (OFLA leave only) _____Yes _____No

Have you taken family leave in the past 12 months? _____Yes _____No
If yes, how many workdays? __________

_____ 6. A qualifying exigency arising from an employee's spouse, son, daughter, or parent who is a covered servicemember, or leave for the spouse or domestic partner of a military personnel per each deployment of the spouse or domestic partner when the spouse or domestic partner has either been notified of an impending call to active duty, has been ordered to active duty, or has been deployed or on leave from deployment.

_____ 7. To care for the serious illness or injury of a spouse, son, daughter, parent, or next of kin[2] who is a covered servicemember with a serious illness or injury incurred in the line of duty or active duty in the armed forces. Has leave been taken for the same servicemember and the same injury? ____ Yes _ No

If yes, when was the leave taken and for how many work days? _________________

[2] "Next of kin" means the nearest blood relative of the eligible employee.

I understand that I am required to use any accrued paid leave, including personal and sick leave or accrued vacation leave before taking family and medical leave without pay. I may select the order in which the paid leave is used for the family and medical leave period.

If my request for a leave is approved, it is my understanding that without an authorized extension when the need for an extension could be anticipated, I must report to duty on the first work day following the date my leave is scheduled to end. I understand that failure to do so will constitute unequivocal notice of my intent not to return to work and the district may terminate my employment.

I authorize the district to deduct from my paychecks any employee contributions for health insurance premiums, life insurance or long-term disability insurance which remain unpaid after my leave, consistent with state and/or federal law.

I have been provided a copy of the district's family and medical leave policy with this family and medical leave request form.

* A physicians certification may be required to support a request for family and medical leave. In addition, a fitness for duty certification may be required before reinstatement following the leave.

Signature of Employee: ______________________________ Date____________

Completed form must be provided to SHSD Human Resources/Payroll.

To be completed by the Department Representative.

______ Leave of absence approved
______ Leave of absence denied
Denied reason(s):
______ Employee has not been employed by district for 12 months.
______ Employee has not worked 1250 actual work hours in past 12 months.
______ Leave of absence conditionally approved pending receipt of medical certification.
Medical certification due by ______________

______________________________ ______________________________
Superintendent Signature Date

To be completed by Payroll.

Medical certification received on ________________
______ Leave of absence approved
______ Leave of absence denied
______ Non-qualifying reason(s)
______ Calendar year allotment of FMLA (12 weeks) exhausted
______ Medical certification not provided

______________________________ ______________________________
Payroll Supervisor Signature Date

HEALTH CARE PROVIDER CERTIFICATION
Family and Medical Leave
St. Helens School District #502

This form is used to provide certification per FMLA and OFLA regulations and law.

Section I: Employee Completes this Section

Employee's name: ______________________________

Patient's name: ______________________________

(Please check one) Relationship to patient:

☐ self ☐ spouse ☐ parent ☐ child (age _____) ☐ domestic partner ☐ parent-in-law
☐ grandparent ☐ grandchild ☐ parent of domestic partner ☐ child of a domestic partner (age ___)

Section II: Health Care Provider Completes this Section

Please complete all sections in order for the agency to determine Family and Medical leave entitlement.

Caution: *Per the Genetic Information Nondiscrimination Act of 2008 (GINA) this agency is not requesting or requiring genetic information* of its employees or their family members. In order for us to comply with this law, we ask that you not provide any genetic information when responding to this request for medical information.*

1. Please mark all that pertain to this patient (descriptions are on Page 2 of this certification):
   A. ☐ Requires hospital care (hospice, residential care facility)
   B. ☐ Requires absence from work plus treatment
   C. ☐ Pregnancy disability or requires prenatal care
   D. ☐ Chronic condition requiring treatment
   E. ☐ Permanent or long-term condition requiring supervision
   F. ☐ Requires multiple treatments for a non-chronic condition
   G. ☐ None of the above

Describe the medical facts that support your above certification. ______________________________
____
____

2. Approximate date this condition began? ______________________________

3. Probable duration of the patient's present incapacity? (from)________________(to)________________

4. Is this for either a chronic condition or for pregnancy? ☐ yes ☐ no If yes, is the patient presently incapacitated? ☐ yes ☐ no If yes, what is the expected duration of the incapacity? ______________________________
What is the expected frequency of the incapacity? ______________________________

5. Will it be necessary for the employee to take time off intermittently or work on a reduced schedule due to the patient's condition or treatment? ☐ yes ☐ no If yes, what is the expected frequency for the absence?
☐ ______days per week, ☐ ______ days per month, ☐ reduce hours worked in a day to ______ for ______ days per week, ☐ other (describe) ______________________________

6. Will the patient require a regimen of treatments? ☐ yes ☐ no If yes, describe the nature of the treatments, number of treatments needed and the intervals between treatments ______________________________
____

7. If the patient is not the employee, will the patient need assistance for basic medical or personal needs, or safety or transportation? ☐ yes ☐ no ☐ n/a patient is the employee If no, would the employee's presence to provide psychological comfort be beneficial or assist in the patient's recovery? ☐ yes ☐ no

______________________________ ______________________________ ________________
Signature of Health Care Provider Printed Name of Health Care Provider Date Signed

Field of practice ______________________Health care provider address: ____________________

***Return this form to the patient** or fax (marked CONFIDENTIAL) to the attention of Human Resources at Fax 503-397-1907 , St. Helens School District #502*

DEFINITIONS

This page defines the various serious health condition categories listed in section 1, A-G on the front of this certification and other terms. **A "serious health condition" is defined as an illness, impairment, physical or mental condition that involves one or more of the following:**

A. 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 as a consequence of such inpatient care.

B. Absence plus treatment: A period of incapacity of more than three consecutive calendar days, including any subsequent treatment or period of incapacity relating to the same condition, that also involves one or both of the following:

a. Treatment received in person, two or more times by a health care provider, a nurse, or a physician's assistant under direct supervision of a health care provider, or a provider of health care services (e.g., physical therapist) under orders of or referred by a health care provider.

b. Treatment by a health care provider on at least one occasion resulting in a regimen of continuing treatment under the supervision of the health care provider.

c. Regimen of Continuing Treatment: Includes a course of prescription medication such as an antibiotic or physical therapy requiring special equipment to resolve or alleviate the health condition. A regimen of treatment does not include taking over-the-counter medications such as aspirin, antihistamines or salves, bed-rest, drinking fluids, exercise, and other similar activities that an individual can initiate without a visit to a health care provider.

C. Pregnancy or pregnancy disability: Any period of incapacity for pregnancy, pregnancy-related illness including severe morning sickness, or for prenatal care or post pregnancy recovery.

D. Chronic conditions requiring treatments: A chronic serious health condition is one which:

a. Requires periodic in-person treatments 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.

c. May cause episodic rather than continuing periods of incapacity; for example, asthma, diabetes, epilepsy.

E. Permanent or long-term conditions requiring supervision: A period of incapacity that is permanent or long-term due to a condition for which treatment is potentially ineffective. The employee or family member is under supervision of a health care provider, not necessarily receiving active treatment. Examples are Alzheimer's disease, a severe stroke, the terminal stages of a disease.

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

G. None of the above: The patient does not have a serious health condition as described above.

Incapacity: The inability to work, attend school or perform other regular daily activities due to a serious health condition or treatment for or recovery from a serious health condition.

***Genetic information:** Information about: i) An individual's genetic tests; (ii) The genetic tests of that individual's family members; (iii) The manifestation of disease or disorder in family members of the individual (family medical history); (iv) An individual's request for, or receipt of, genetic services, or the participation in clinical research that includes genetic services by the individual or a family member of the individual; or (v) The genetic information of a fetus carried by an individual or by a pregnant woman who is a family member of the individual and the genetic information of any embryo legally held by the individual or family member using an assisted reproductive technology.

Agency Form Number (optional) ________
DAS Healthcare Certification PD 615A (01-15-09)
Note: the agency may not alter this form except to add an agency form number, the name of the agency and the fax number.