

OREGON HEALTH & SCIENCE UNIVERSITY
Employee Request for Family Medical Leave (FMLA/OFLA)
(When possible, must be requested 30 days in advance)

Name _____ Employee ID _____ Today's Date _____

Department _____ Supervisor _____ Supervisor Ext. _____

Timekeeper _____ Timekeeper Ext. _____

Instructions

- Employee: complete and return this form to the Benefits office at OHSU (mail code: Benefits, HR or fax, 503-494-5990).
- Check all boxes that apply to your request for leave.
- Read the entire form, sign it, and keep a copy for your records.

Eligibility

Federal Family and Medical Leave Act (FMLA)

Eligibility: Employees who have been employed **at least** 12 months and worked **at least** 1,250 hours

Oregon Family Leave Act (OFLA)

Eligibility: Employees who have been employed **at least** 180 days (parental leave) or have been employed at least 180 days and worked an average of 25 hours per week (other OFLA leave).

Leave Reason

I need to take family leave due to:

- My own serious health condition **Complete and return Medical Certification**

- The birth or the placement for adoption or foster care of a child in my care ("parental leave")
Anticipated delivery date of child _____
Anticipated date of physical custody of child _____

- A serious health condition of a family member or next-of-kin **Complete and return Medical Certification**
Name of seriously ill family member _____
Relationship to Employee _____
If child of employee, date of birth _____
Is care related to injury sustained during active military duty? _____

- Exigent circumstances related to call to active military duty of family member. **Complete and return Certification**

Duration of Leave

I anticipate that my leave will start on _____. If I take an uninterrupted block of time, I expect that my leave will end no later than _____. I request that the leave be taken as

A block of time Yes No

Intermittent leave Yes No

A reduced schedule Yes No

If intermittent or reduced schedule, indicate the expected schedule _____

Is this leave the result of an on-the-job accident or illness Yes No

I prefer to have information sent to: my OHSU e-mail my home mailing address _____

Family Medical Leave Policy

The rights and responsibilities of employees and OHSU under FMLA/OFLA are prescribed in OHSU Policy No. 03-25-015. Subjects include: eligibility, reasons for leave, duration of leave, definitions, leave request and leave designation, reporting medical certification, continuation of benefits, reinstatement, and failure to return to work after protected leave. Your rights and responsibilities for reinstatement to the same or an equivalent position with the same pay, benefits and terms and conditions of employment on your return from FMLA and/or OFLA leave are listed in the policy.

- When leave qualifies under both OFLA and FMLA, the leave will be counted against the employee's entitlement under both leave laws and the employee's entitlement will be reduced accordingly.
- You have a right under FMLA/OFLA for up to 12 weeks unpaid leave in a calendar year for qualifying reasons. Additional OFLA leave during the calendar year may be taken for a condition related to pregnancy or childbirth that disables the employee or for "sick child care" as prescribed in the policy.
- An employee who fails to return to work at the conclusion of an approved FMLA or OFLA leave may be deemed to have voluntarily terminated his or her employment. Leave may be designated as FMLA/OFLA absence at the employer's request.

Medical Certification

I understand a medical certification is required within **15 calendar days** of my request to determine if my leave qualifies as a serious health condition under the Federal Family and Medical Leave Act (FMLA) and/or the Oregon Family Leave Act (OFLA). A medical certification may also be requested by policy, contract or if more than three days of leave are taken to care for a child with a health condition requiring home care.

Continuation of Benefits

Your health insurance benefits under FMLA must be maintained by OHSU up to 12 weeks during any period of leave under the same conditions as if you continued to work. Your health insurance benefit will not be maintained during any unpaid OFLA leave but you will be offered continuation of coverage under COBRA. If you do not return to work following the leave for a reasons other than: 1) the continuation, recurrence, or onset of a serious health condition which would entitle you to leave; or 2) other circumstances beyond your control, you may be required to reimburse OHSU for any share of health insurance paid on your behalf during the leave.

- You are required to use all accrued sick leave while on FMLA and OFLA.
- You may elect to continue insurance coverage under the other voluntary benefit plans (STD, LTD; supplemental life; spouse life; dependent life. I elect to **continue** **decline my voluntary benefit plans.**
- While on medical leave you are responsible for your portion of benefit premiums if any portion of your leave is unpaid from OHSU. Premiums due will be deducted through payroll upon your return to work or you can pay them during your leave. Contact the Benefits Office for information on the payment process.

While on Leave and Returning to Work

- While on leave, you may be required to furnish OHSU with periodic updates of your status and intent to return to work.
- If the circumstances of your leave changes and you are able to return to work earlier than the date indicated on the reverse side of this form, you will be required to notify your manager at least two days prior to the day you intended to report to work and provide a written release from your provider.
- You may be required to furnish re-certification relating to a serious health condition as prescribed in 825.308 of the FMLA regulations.
- If the leave is for your own serious health condition, you may be required to present a written release from your provider prior to being restored to employment. If a written release is not received by your manager, your return to work may be delayed until a written release is provided.

Employee Signature

Date

FOR BENEFITS OFFICE USE

Process date _____