WEST LINN – WILSONVILLE SCHOOL DISTRICT

Family and Medical Leave Act (FMLA) and/or Paid Leave Oregon Request Form (OFLA for few reasons - i.e. bereavement)

Employee Name_____ Today's Date_____

Employee ID Number_____ School_____

Effective Date of the Leave: From_____ through_____.Number of days _____

Will this leave be intermittent? ☐Yes; ☐No;

Hire Date:_____. Have you taken a family/medical leave in the past 12 months?_____

Reason: ☐Birth of child; ☐Adoption; ☐Care for family member; ☐Serious health condition.

Details:_____

Are you applying for Paid Leave Oregon? ☐Yes; ☐No; ☐Unsure (If this box is checked, reach out to Shyla Waldern in HR once you have decided: WaldernS@wlwv.k12.or.us)

If you are taking parental leave, have you received the FAQ document for taking leave? ☐Yes; ☐No; ☐ N/A (I am not taking parental leave)

Employee Signature_____ Date_____

Best contact phone number**:** _____

Please read: If you are requesting Family and Medical Leave (FMLA) or Oregon Family Leave (OFLA), please complete and attach the Medical Certification Form.

PLO and/or OFLA Qualifying Circumstance:	**FMLA Qualifying Circumstance:**
The employees own serious health condition: • Critical illness or injuries diagnosed as terminal or which pose an imminent danger of death • Inpatient Care • Any period of disability due to pregnancy or prenatal care • Requires "constant" or "continuing" care such as home care administered by a health care provider, conditions that are chronic, in a health care facility, conditions that meet the federal continuing treatment definition Serious health condition of employee's family member. Newborn, newly adopted, or newly placed foster child "Parental Leave" Non-serious health condition of a child requiring home care Leave for spouse or same-sex domestic partner of a service member called to active duty Leave to deal with the death of a family member (2 weeks - OFLA only) ORS 659.470(6), OAR 839-009-0210(9), (10)	The employees own serious health condition • An illness, injury, impairment or physical or mental condition that requires an overnight stay in a medical facility • Continuing treatment due to an incapacity lasting more than three consecutive days and including two or more treatments by a health care provider or one treatment with a continuing regimen of treatment. • Any period of incapacity due to pregnancy or prenatal care. • Conditions that are chronic • Multiple treatments for restorative surgeries or for conditions that would likely result in a period of incapacity of more then three days without treatment. Serious health condition of employee's family member Newborn, newly adopted or newly placed foster child "Parental Leave" Any "qualifying exigency" arising out of the fact that the employee's family member is on active duty or an eligible employee who is the family member or next of kin of a military service member who is recovering from a serious illness or injury sustained in the line of duty on active duty 29 CFR § 825.114

☐Approved. Signature_____ Date_____

☐Not approved. Signature_____ Date_____

Confidentiality: Any disclosure of medical information will be kept in a confidential file and will be used only to determine eligibility for OFLA/FMLA and to track leave.

WEST LINN – WILSONVILLE SCHOOL DISTRICT
22210 SW Stafford Rd. Tualatin, OR 97062

FMLA MEDICAL CERTIFICATION FORM—To be completed by Health Care Provider

Employee Name: _____ Today's Date: _____

Employee's Job Title: _____ Job Description Attached: ☐ Yes ☐ No

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

Relationship of family member for whom employee will provide care: _____

Does the patient's condition for which the employee is taking FMLA leave fit into one of the following categories:

_____Because of the birth of a child;
_____Because of the placement of a child for adoption or foster care;

_____In order to care for a family member with a serious health condition;
_____For a serious health condition which prevents the employee from performing job functions;
_____None of the above.

Other:_____

1. Please describe the medical facts which support your certification, including a brief statement as to how the medical facts meet the criteria of one of these categories:

2. Was the patient admitted for an overnight stay in a hospital, hospice or residential medical care facility?

   ☐ Yes ☐ No If yes, please list dates of admission: _____

3. Will the employee/family member be incapacitated for a single continuous period of time due to his/her medical condition, including any time for treatment and recovery?

   ☐ Yes ☐ No If yes, please estimate beginning and ending dates for the period of incapacity :_____

   _____

4. State the approximate date the condition commenced and the probable duration of the condition:

5. Will it be necessary for the employee to work only intermittently or to work on a less than full schedule as a result of the condition, including treatment and recovery time?

   ☐ Yes ☐ No If yes, please provide probable duration: _____

6. If the condition is a chronic condition or pregnancy, state whether the patient is presently incapacitated and the likely duration and frequency of episodes of incapacity:

7. If additional treatments will be required for the condition, provide an estimate of the probable number of such treatments, actual or estimated dates of treatment, if known, and period required for recovery, if any:

8. If any of these treatments will be provided by another provider of health services (*e.g.,* physical therapist), please state the nature of the treatments:

9. If a regimen of continuing treatment by the patient is required under your supervision, provide a general description of such regimen (*e.g.,* prescription drugs, physical therapy requiring special equipment):

10. If medical leave is required for the employee's absence from work because of the employee's own condition, is the employee unable to perform work of any kind (please review the attached job description)?

11. If able to perform some work, is the employee unable to perform any one or more of the essential functions of the employee's job? If yes, please list essential functions the employee is unable to perform:

12. If a leave is required to care for a family member of the employee with a serious health condition, does the patient require assistance for basic medical or personal needs or safety, or for transportation?

13. If no, would the employee's presence to provide psychological comfort be beneficial to the patient or assist in the patient's recovery?

14. If the patient will need care only intermittently or on a part-time basis, please indicate the probable duration of this need:

Signature of Health Care Provider

Printed name of Health Care Provider

Address

Telephone

Type of Practice

To be completed by the Employee needing family leave to care for a family member:

State the care you will provide and an estimate of the period during which care will be provided, including a schedule if leave is to be taken intermittently or if it will be necessary for you to work less than a full schedule:

Employee's Signature

Date

West Linn-Wilsonville School District
District Contact: Shyla Waldern, Director of HR
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22210 SW Stafford Rd.
Tualatin, Oregon 97062
Phone: 503 673-7018
Fax: 503 673-7001