CONFIDENTIAL

CLACKAMAS COUNTY FAMILY MEDICAL LEAVE REQUEST FORM

EMPLOYEE INFORMATION

NAME				ADDRESS			
EMPLOYEE ID		DATE HIRED		CITY			
DEPT				STATE		ZIP	

How would you like to receive leave correspondence? ☐ Email ☐ Mail

If via email, please provide your personal email address: _____

REQUESTED LEAVE INFORMATION

ESTIMATED DATES OF LEAVE (required): FROM: _____ TO: _____

TYPE OF LEAVE (mark only one) ☐ Continuous (more than 3 consecutive days) **OR** ☐ Intermittent

*If you need more than one leave type, please complete another Leave Request Form

LEAVE REASON

☐ Care for my own serious health condition.

☐ Care for a family member with a serious health condition. Specify relationship _____
If the family member is a child, please give the age of the child _____

☐ Parental Leave for birth, adoption or foster care placement of a child. Estimated due date _____

☐ Pregnancy disability (female employees – includes prenatal care, childbirth and recovery).
Estimated due date _____

☐ Care for a family member who is a military member with a serious health condition.
Specify relationship_____

☐ OFLA Bereavement leave following death of a family member. Specify relationship _____

☐ OFLA Sick Child leave for your child with an illness or injury that requires home care, not a medical exam. Medical certification may be requested after the third occurrence of sick child leave.
Name of child(ren) being cared for:_____
Age(s) of child(ren):_____ Specify relationship:_____
For any child older than 14, please identify what special circumstances exist requiring you to provide care:
_____
Name of school or childcare provider that is closed: _____
I affirm that no other family member is willing and able to care for the child ☐ Correct ☐ Incorrect

☐ Qualifying exigency leave. Specify relationship _____

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 any approved leave will count towards my annual leave entitlement.
- I understand that I must complete and return the **Certification of Health Care Provider** form within 15 calendar days.
- I agree I will not work for another employer while on leave.
- If leave is for my own serious health condition for a continuous period of more than 3 consecutive days, I understand that I may not return to work until I provide a completed **Release to Return to Work** form or note from my provider.
- I understand that I am responsible for notifying my supervisor when absences are due to family medical leave reasons.
- I agree that if I am in an unpaid status during my leave, then I will be responsible for paying my share of any applicable benefit premiums, either during the leave or as a payroll deduction immediately upon return from leave.
- I understand that any period of paid disability leave may count toward Family and Medical Leave.
- I agree that if I choose not to return to work at the end of the leave, I will reimburse the County for the cost of County-provided health benefits for any period of LWOP during my leave. If I am unable to return because of the continuation, recurrence or onset of a serious health condition or other circumstances beyond my control, this provision will not apply.
- If I am unable to return to work at the end of the leave period because of my own or my family member's serious health condition, I will provide medical certification from the appropriate health care provider. This statement must show that on the date my leave expired I was unable to perform the functions of my position or that I still am needed to care for my family member because he/she has a serious health condition.
- I understand that if I do not return to work at the end of my approved leave time, my employment may be terminated by the County as of the date my leave expired and that I have no reinstatement rights.

REQUESTED USE OF ACCRUED PAID LEAVE

Own or Family Member's Illness/Injury

(EA, CCOM and FOPPO members skip to the next section)*

Select pay options (you are required to use your Sick hours first):

☐ Use my accruals* **OR** ☐ Leave Without Pay

*Specify order (#1- #3):

___ Vacation
___ Comp Time
___ Personal Holiday

Parental or Oregon Bereavement Leave

Select pay options:

☐ Use my accruals* **OR** ☐ Leave Without Pay

*Specify the number of hours to retain and in which order:

Accrual Type	Order in which to use accruals	Number of hours to retain
Sick		
Vacation		
Comp Time		
Personal Holiday		

*EMPLOYEES' ASSOCIATION , CCOM and FOPPO Members

You **must** use vacation after sick leave becomes exhausted for own or family member's illness/injury. Up to 40 hours of vacation may be retained before unpaid leave is used.

- Specify the number of *vacation* hours you would like to retain (up to 40) _____
- Specify the order in which you would like to use your accrued paid time:

#1__Sick #2__Vacation ___ Comp Time ___ Personal Holiday

SUPERVISOR NOTIFICATION

When leave is anticipated, the employee must notify his or her non-union supervisor at least thirty (30) calendar days in advance of the leave. In situations where an emergency arises and the need for the leave is not anticipated, the employee must notify his or her non-union supervisor as soon as practical.

Provide the date you have notified your non-union supervisor of your leave request _____

ADDITIONAL COMMENTS

EMPLOYEE SIGNATURE

Employee's Signature _____ Date _____

PLEASE CHECK IF YOU WOULD LIKE ADDITIONAL INFORMATION ON THE FOLLOWING:

☐ Filing a Disability Claim: Employees who are going out on a full time, continuous leave of absence for their own condition that will be longer than 30 days have the right to file a disability claim.

☐ Donated Leave Program: The donated leave program is available to eligible employees. Non-represented employees in the County may participate in this program irrespective of union participation or agreement. Members of the Peace Officers Association have a separate program and should reach out to their department for more information.