

Portland Public Schools
EMPLOYEE LEAVE REQUEST

(For any absence that extends for a period of more than five (5) workdays)

Employee Name _____ Employee ID# _____ Dept# _____

Assignment/Job Title _____ Work Site _____

Home Address _____ Home Telephone _____

City/State/Zip _____ Work Telephone _____

A. INSTRUCTIONS FOR EMPLOYEES You must complete a Leave Request form (sections B - D) for any absence of more than five (5) workdays. Submit the completed form to your supervisor. Without a supervisor's signature, your leave request may be delayed. Complete this form before leave is taken to ensure it has been approved. Human Resources (HR) may need to ask for additional information to determine FMLA/OFLA eligibility. See page three (3) of form for explanation of qualifications for FMLA/OFLA. Leave which does not qualify as FMLA and/or OFLA may still be taken subject to Board Policy and applicable negotiated agreements.

B. REQUEST FOR LEAVE

1. Beginning Date of Absence _____ Anticipated Return to Work Date _____

2. I am requesting leave for full-time/all of my assignment or part-time/FTE or hours per day/week _____

C. REASON FOR LEAVE (You must provide the requested documentation as noted below.)

MEDICAL/FAMILY MEDICAL/PREGNANCY/PARENTAL LEAVE - Please check the appropriate box

- My own serious health condition: **Completed Certification of Health Care Provider form or other medical documentation from a health care provider**
- Pregnancy: **Written medical documentation from a health care provider**
- A serious health condition for which you are needed to provide care for an immediate family member:
State relationship of family member _____
Completed Certification of Health Care Provider form or other medical documentation from your family member's health care provider
- Parental Leave for the birth of your child or adoption of a child: Leave Request form only
Expected Date of Birth _____ **and/or** Expected Date of Physical Custody _____
- Parental Leave/Foster Care: You must register a document showing legal guardianship
Date of Birth _____ **and/or** Expected Date of Physical Custody _____
- An illness or injury that is not a serious health condition affecting your child during which you are needed to provide home care

OTHER LEAVE - Please check the appropriate box

- Association/Federation/Union: Verification of contractual arrangements
- Employment in an Institution of Higher Learning: Verification of contractual arrangements
- Exchange and Other Teaching: Specifics of leave/verification of contractual arrangements
- Military: Military Orders
- Political: Completed Leave Request form only
- Scholarship: Official verification from granting agency
- Career Development Leave: Program of study and evidence of completion at expiration of leave
- Unpaid Childcare: Unpaid leave following the use of 12 weeks of parental leave-Completed Leave Request form only
- Program/Department Needs: Completed Leave Request form only
- Other: You must attach a written statement indicating specifics of why you are requesting an unpaid leave

NOTE: If you are requesting an altered or reduced work schedule for medical reasons, either for yourself or family members, please indicate your scheduling needs: _____

D. SUPERVISOR AKNOWLEDGEMENT

SUPERVISOR NAME _____ **SIGNATURE** _____ **DATE** _____

My signature indicates only that I have been notified and reviewed this employee's request for a leave of absence.

(Special Education and ESL: have your school principal or department supervisor sign this form as well)

SUPERVISOR NAME _____ **SIGNATURE** _____ **DATE** _____

My signature indicates only that I have been notified and reviewed this employee's request for a leave of absence.

E. EMPLOYEE SIGNATURE _____ **DATE** _____

My signature indicates that I understand it is my responsibility to contact HR (503-916-3544) for information regarding continuation of my district provided health and welfare benefits. Should I choose to continue insurance benefits on a self-pay basis, it is my responsibility to call Benefits (503-916-3065) regarding options for continuation of benefits on a self-pay basis during my unpaid leave. When I return from unpaid leave, it may be necessary to complete new insurance forms to reinstate the District's contribution for my coverage. This is true whether or not I self-pay for benefits while on leave.

If I am a licensed employee requesting unpaid leave, I must inform HR in writing, no later than November 15 or March 15 of my intention to return at the beginning of the school term following expiration of my leave.

PLEASE RETURN COMPLETED FORM WITH THE APPROPRIATE MATERIALS TO

*Department of Human Resources, BESC, P.O. Box 3107, Portland, OR 97208-3107 or fax to 503-916-3107
If you have questions, please call Jodie Benson at 503-916-3301*

HUMAN RESOURCES TO COMPLETE

Total of accumulated paid leave as follows:

_____ Hours of full paid sick leave (Divided by 8 for full days) _____

_____ Hours of 2/3rd paid reserve (Divided by 8 for full days) _____

_____ Hours of Emergency/Personal Business Leave _____ Hours of Family Illness Leave

_____ Hours of paid vacation (if applicable)

Eligible paid leave:

Date from _____ Date through _____

Additional period of unpaid leave:

Date from _____ Date through _____

FMLA Eligible / Dates: _____ Not Eligible / Reason: _____

OFLA-Medical Eligible / Dates: _____ Not Eligible / Reason: _____

OFLA-Parental Eligible / Dates: _____ Not Eligible / Reason: _____

HR Approval _____ **Date** _____

FMLA/OFLA INFORMATION

OREGON FAMILY LEAVE ACT (OFLA) Definition of a Serious Health Condition

- Critical illnesses or injuries diagnosed as terminal or which pose an imminent danger of death.
- Inpatient care.
- Any period of incapacity due to pregnancy or prenatal care.
- Conditions requiring “constant care”:
 - In a health care facility;
 - Home health care administered by health care professionals;
 - Conditions that are chronic, which require in-patient care or constant care;
 - Conditions that meet the definition of “Serious Health Condition”.

ORS 659.470(6), OAR 839-009-0210(9), (10).

FEDERAL FAMILY AND MEDICAL LEAVE ACT (FMLA) Definition of a Serious Health Condition

- Inpatient care.
- 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 than three days without treatment.
- Continuing treatment due to an incapacity
 - i. Lasting more than three consecutive days; and
 - ii. Including two or more treatments by a health care provider or one treatment with a continuing regimen of treatment.
- The “three-day rule” does not apply to:
 - Absences for pregnancy related disability;
 - Absences for prenatal care;
 - Absences for serious chronic conditions;
 - Absences for multiple treatments.

29 CFR §825.114.

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PROGRAM

TECHNICAL ASSISTANCE FOR EMPLOYERS

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Oregon Bureau of Labor and Industries

A same-sex domestic relationship is defined as follows:

- The same-sex domestic partners are not related by blood closer than would bar marriage in the State of Oregon (first cousins or nearer);
- --Neither is legally married;
- --They have continuously lived together as a family and share a close personal relationship, which is exclusive and loving, for an extended period of time, and they intend to maintain that family and that relationship with each other for the rest of their lives;
- --They have joint financial accounts and have agreed to be jointly responsible for each other's common welfare, including basic living expenses;
- --They would be married to each other if the law permitted them to marry in Oregon;
- --They are the sole domestic partner of each other and have no other domestic partner;
- --They are both 18 years of age or over, and
- --They are each homosexual

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