Amity School District 4J

Code: **GCBDA/GDBDA-AR (2)**
Adopted: 3/14/94
Revised/Readopted: 9/14/94, 5/08/96, 5/10/00, 04/14/04, 3/12/08, 09/09/09, 08/18/10, 10/09/13, 01/15/14, 01/13/2016, 08/16/17

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 _____

Department _____ Title _____

Status: ☐ Full Time ☐ Part Time ☐ Temporary

Hire Date _____ Length of Service _____

Have you taken a family leave in the past 12 months? _____ Yes _____ No
If yes, how many work days? _____ Reason for leave_____

I request family or medical leave for one or more of the following reasons:* [1]

_____1. Because of the birth of my child and in order to care for him or her. (District: Use GCBDA/GDBDA-AR(3)(A) Certification Form)
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. (District: Use GCBDA/GDBDA-AR(3)(A) Certification Form)
Age of child _____Date of placement _____
Leave to start _____ Expected return date _____

_____ 3. In order to care for a family member[2] with a serious health condition. (District: Use GCBDA/GDBDA-AR(3)(B) Certification Form)
Leave to start_____ Expected return date _____

Please check one:_____ Spouse[3]_____ Child[4]_____ Parent_____Individual who was in *loco parentis* when the employee was a child _____ Parent-in-law or the parent of the employee's registered domestic partner

[1]A physician's 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.

[2]"Family member" for purposes of FMLA and OFLA leave, means the spouse, same-sex domestic partner, custodial parent, noncustodial parent, adoptive parent, stepparent or foster parent, biological parent, child of the employee (biological, adopted, foster or step child, a legal ward, or child of the employee standing in loco parentis), same-gender domestic partner, the child of a same-gender domestic partner or a person with whom the employee is or was in a relationship of "in loco parentis." Additionally, when defining "family member" under OFLA (but not FMLA leave), the definition includes, grandparent, grandchild, parent-in-law or parent of the employee's same-gender domestic partner.

[3]"Spouse" means individuals in a marriage including "common law" marriage and same-sex marriage. For OFLA, spouse also includes same-sex individuals with a Certificate of Registered Domestic Partnership.
[4]~~For FMLA, the age of the son or daughter is not relevant in determining a parent's entitlement to FMLA leave.~~

(OFLA leave only) _____custodial parent _____non-custodial parent _____ adoptive parent
_____Stepparent _____foster parent ____Grandparent (OFLA leave only) ____ Grandchild (OFLA leave only.)

Please state name and address of relation:

Name_____ Address _____

Does the condition render the family member unable to perform daily activities? _____

_____4. For a serious health condition which prevents me from performing my job functions. (District: Use GCBDA/GDBDA-AR(3)(A) Certification Form) 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).

_____6. A qualifying exigency arising from an employee's spouse, son, daughter, or parent who is a covered service member as defined in GCBDA/GDBDA-AR(1), or leave for the per each deployment of the spouse when the spouse 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. (District: Use GCBDA/GDBDA-AR(3)(C) Certification Form)

_____7. To care for a spouse, son, daughter, parent, or next of kin[5] who is a covered service member 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 service member and the same injury? _____ Yes __ No (District: Use GCBDA/GDBDA-AR(3)(D) Certification Form) If yes, when was the leave taken and for how many work days? _____

_____8. For the death of a family member (OFLA only).

I understand that I may use any available accrued paid leave, including personal and sick leave or available accrued vacation leave for the leave period subject to specifications in Board policy(ies) or the collective bargaining agreement.

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. (A fitness-for-duty certification may be required.)

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 and a copy of my rights and responsibilities under the Family Medical Leave Act leave request form.

Signature of Employee: _____Date: _____

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