FAMILY AND MEDICAL LEAVE REQUEST FORM

PART I – EMPLOYEE INFORMATION (Fill in info and check the option that applies)

Name: _____ V#: _____

Hire Date: _____ Title/Department: _____

Employee Phone Number: _____ Supervisor Phone Number: _____

PART II – REASON FOR LEAVE (Check all that apply)

FMLA/OFLA - To qualify for this protection, you must have been employed by WOU for at least 12 months (need not be consecutive service time) and have 1250 hours of service in the 12 months immediately preceding the leave. Maximum Leave: 12 weeks in a 12-month rolling calendar period.

- ☐ A Serious Health Condition - including pregnancy related conditions.*****
- ☐ Your Family Member's Serious Health Condition – including spouse, parent (not parent in-law), child under 18, or child 18 or older if incapable of self care because of a mental or physical disability. *****
- ☐ Parental Leave - during the year following the birth of a child, newly adopted, or newly placed foster child
- ☐ Qualifying Exigency Leave - leave to tend to exigencies resulting from your spouse, parent, or child being called into federal active duty.
- ☐ Military Caregiver leave – leave to care for your spouse, parent, child or next of kin, who is a covered service member with a serious injury or illness incurred in the line of duty on federal active duty.

OFLA/FMLA DEFINITIONS

- **Inpatient care** (hospitalization).
- **Absence from work for more than 3 calendar days that involves continuous treatment of a health care provider (2 or more treatments required).**
- **Absence for a chronic or long-term health care condition that is incurable or so serious, that if untreated would likely result in a period of incapacity of more than 3 calendar days.**

OFLA - To qualify for this protection, you must have been employed for the 180 day calendar period immediately preceding the leave and have worked at least an average of 25 hours per week during the 180-day period. Maximum Leave: 12 weeks in a 12-month rolling calendar period.

- ☐ Care for your, same-sex domestic partner, parent of same sex domestic partner, adult child, minor or disabled child of same-sex domestic partner, or parent in-law, grandparent, or grand child who has serious health condition.*****
- ☐ Care for a minor child with an illness or injury that isn't a serious health condition but requires home care.*****
- ☐ Leave for same-sex domestic partner called to active duty, or who is on leave from active duty.
- ☐ Domestic Violence Leave - Victims of Certain Crimes Leave Act (OVCCLA).
- ☐ Oregon Family Military Leave Act - leave for the spouse or same-sex domestic partner of a service member who has been called, notified of an impending call, or is on leave from active duty
- ☐ Bereavement Leave - to deal with the death of a family member (Max. 2 weeks/qualifying family member).
- ☐ Employee is unable to work or telework because the employee is caring for his or her child whose school or place of care is closed (or childcare provider is unavailable) due to COVID-19 related reasons. Please provide the following:
  Name of child(ren) being cared for:_____
  Age of child(ren) being cared for: _____
  Name of school, please of care, or childcare provider that has closed or become unavailable:
  _____
  No other suitable person (such as co-parent, co-guardian, or the usual care provider) is available to care of the child(ren) during the period for which employee is requesting FF leave: ☐ Correct ☐ Incorrect

**Medical Certification Form Required*
If leave qualifies under both the FMLA and OFLA, or the FMLA and contractual benefit provisions, its use is counted against both entitlements concurrently.

PART III – LEAVE REQUEST AND ALLOCATION

I request a leave of absence under the Family and Medical Leave Act (FMLA) and/or under the Oregon Family Leave Act (OFLA):

□ I am requesting leave in a block of time beginning on _____ and ending on _____.

□ I am requesting intermittent or reduced hours beginning on_____. (Please attach modified schedule).

Allocation of accrued leave:
NOTE: FMLA/OFLA provides up to 12 weeks of unpaid, job-protected leave to eligible employees.

□ I am an eligible employee, I am aware of my current leave balances, will have enough accrued leave to cover my absence and plan to use my accrued leave during my absence.

□ I am an eligible employee and I plan to apply for use of my Standard disability insurance to cover my absence. I understand that I may elect in writing to be moved to leave without pay (LWOP) prior to or in addition to using my accrued leave.

□ I am an eligible employee, aware of my current leave balances, and will not have enough accrued leave to cover my absence: (Please also indicate a choice below).

- □ I am an eligible employee and I wish to be moved to leave without pay (LWOP) status once my applicable accrued leave has been exhausted. (If a classified employee I understand I am eligible to retain 40 hours of vacation for use after returning from leave. I will make a written request if I choose to retain accrued vacation. I understand that retaining accrued vacation time will make me ineligible for Hardship leave.)
- □ I am a **classified** employee and I will apply for the use of Hardship Leave in accordance with Article 40, Section 8 of the SEIU Collective Bargaining agreement after my accrued leave is exhausted.
- □ I am an **unclassified** employee and I am herby requesting an unearned sick leave advance. I understand that once I return, as I accrue sick leave it will go toward repaying any sick leave advanced to me until all time is paid for. I understand that no more than 520-hours of sick leave are available to be advanced during a seven-year period that begins with the first sick leave advance. (Not available to employees in grant funded positions.)
- □ I am an **unclassified** faculty member and I will apply to use the Faculty Leave Bank after my sick leave is exhausted.

PART IV – APPROVAL OF REQUEST

_____ _____
Employee Signature Date

_____ _____
Supervisor Signature Date

_____ _____
Human Resources Signature Date