Philomath School District 17J

Code: GCBDA/GDBDA-AR(3)(A)
Adopted: 6/03/08
Orig. Code: GCBDA/GDBDA-AR(3)(A)

Sample Letter to Employee – FMLA/OFLA Leave

The following is a sample cover letter to an employee notifying the employee that the employer is treating a request for leave as a request for FMLA and/or OFLA leave (either paid or unpaid) that will reduce the employee's FMLA and/or OFLA leave entitlement. This letter should be mailed to the employee within two working days after the employee's request for the leave along with the FMLA/OFLA notice form.

Dear Employee:

On ___(date)____ you advised the district that you were requesting a leave under the Family and Medical Leave Act (FMLA) and/or Oregon Family Leave Act (OFLA). Under our policy, leaves of absence that qualify for family and medical leave under federal law (FMLA) run concurrently with other types of leave such as sick leave, vacation leave, short-term disability leave and leave for a workers' compensation injury or illness. Leaves of absence that qualify for family and medical leave under state laws (OFLA) can run concurrently with other types of leave such as sick leave, vacation leave, short-term disability leave but cannot run concurrently with leave for workers' compensatory injury or illness.

We understand the purpose of your requested leave qualifies as family medical leave under [state] [and/or federal] law. Accordingly, this letter is to notify you that the leave will be counted against your annual family and medical leave entitlement. Also attached is a form entitled FMLA/OFLA Notice to Employee which contains other information for you regarding federal and state family medical leave rights.

Sincerely,

Business Manager

Enclosure (FMLA/OFLA Notice to Employee form)

Corrected 5/2/19

Philomath School District 17J

Code: GCBDA/GDBDA-AR(3)(A)
Revised/Reviewed:

Certification of Health Care Provider

Employee's Serious Health Condition

To be Completed by the District:

The Family Medical Leave Act (FMLA) provides that a district may require an employee seeking FMLA leave protections because of a need for leave due to a serious health condition to submit a medical certification issued by the employee's health care provider. Employees may not be asked to provide more information than allowed under the FMLA regulations. The district will maintain records and documents relating to medical certification, recertifications or medical histories of employee's family members, created for FMLA purposes, as confidential medical records in separate files from personnel files and in accordance with 29 C.F.R. § 1630.14(c)(1), if the Americans with Disabilities Act applies, and in accordance with 29 C.F.R. § 1635.9, if the Genetic Information Discrimination Act applies.

District contact person: _____

Employee's job title: _____ Regular work schedule: _____

Employee's essential job functions: _____

_____

Check if job description is attached: ☐

Return this completed form on _____ (date) (must be at least 15 days after employee is notified of this requirement).

To be Completed by the Employee:

Complete the information below before giving this form to your family member or his/her medical provider. The return of this form is required to obtain or retain the benefit for FMLA protections. Failure to provide a complete and sufficient medical certification may result in a denial of your FMLA request.

Employee's name: _____
First Middle Last

To be Completed by Health Care Provider:

Your patient has requested leave under the FMLA. Answer fully and completely, all applicable parts below. Several questions seek a response as to the frequency or duration of a condition, treatment, etc. Your answer should be the best estimate based upon your medical knowledge, experience and examination of the patient. Be as specific as you can; terms such as "lifetime," "unknown" or "indeterminate" may not be sufficient to determine FMLA coverage. Limit your responses to the condition for which the employee is seeking leave. Do not provide information about genetic tests, as defined in 29 C.F.R. § 1635.3(f), genetic services, as defined in 29. C.F.R. § 1635.3(e) or the manifestation of disease or disorder in the employee's family members, as defined in 29 C.F.R. 1635.3(b). Extra space is provided, should you need it. Please be sure to sign the form on the last page.

Provider's name and business address: _____

Type of practice/medical specialty: _____

_____

Telephone: (___) _____ Fax: (___) _____

Email: _____

Medical Facts

1. The approximate date the condition commenced: _____

   The probable duration of the condition: _____

   Was the patient admitted for an overnight stay in a hospital, hospice or residential medical care facility?
   □ Yes □ No If yes, dates of admission: _____

   List the dates(s) you treated the patient for the condition: _____

   Was medication, other than over-the-counter medication, prescribed? □ Yes □ No

   Will the patient need to have treatment visits at least twice per year due to the condition? □ Yes □ No

   Was the patient referred to other health care provider(s) for evaluation or treatment (e.g. physical therapist)?
   □ Yes □ No

   If yes, state the nature of such treatments and expected duration of treatment:

   _____

   _____

2. Is the medical condition pregnancy? □ Yes □ No

   If yes, expected delivery date: _____

3. Use the information provided by the district in the "To be Completed by the District" section to answer this question. If the district fails to provide a list of the employee's essential functions or a job description, answer these questions based upon the employee's own description of his/her job functions.

   Is the employee unable to perform any of his/her job functions due to the condition? □ Yes □ No

   If yes, identify the job functions the employee is unable to perform:

   _____

4. Describe other relevant medical facts, if any, related to the condition for which the employee seeks leave (such medical facts may include symptoms, diagnosis or any regimen of continuing treatment such as the use of specialized equipment):

   _____

   _____

   _____

Amount of Leave Needed

1. Will the employee 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, estimate the beginning and ending dates for the period of incapacity: _____

   _____

2. Will the employee need to attend follow-up treatment appointments or work part-time or on a reduced schedule because of the employee's medical condition? ☐ Yes ☐ No

   If yes, are the treatments or the reduced number of hours of work medically necessary? ☐ Yes ☐ No

   Estimate treatment schedule, if any, including the dates of any scheduled appointments and the time required for each appointment, including any recovery period:

   _____

   Estimate the part-time or reduced work schedule the employee needs, if any:

   _____ hour(s) per day; _____ days per week from _____ through _____

3. Will the condition cause episodic flare-ups periodically preventing the employee from performing his/her job functions? ☐ Yes ☐ No

   Is it medically necessary for the employee to be absent from work during the flare-ups? ☐ Yes ☐ No

   If yes, explain: _____

   _____

   Based upon the employee's medical history and your knowledge of the medical condition, estimate the frequency of flare-ups and the duration of related incapacity that the employee may have over the next six months (e.g. one episode every three months lasting one to two days):

   Frequency: _____ times per _____ week(s) _____ month(s)

   Duration: _____ hours or _____ day(s) per episode

Additional Information (Identify the question number with your additional answer):

_____

_____

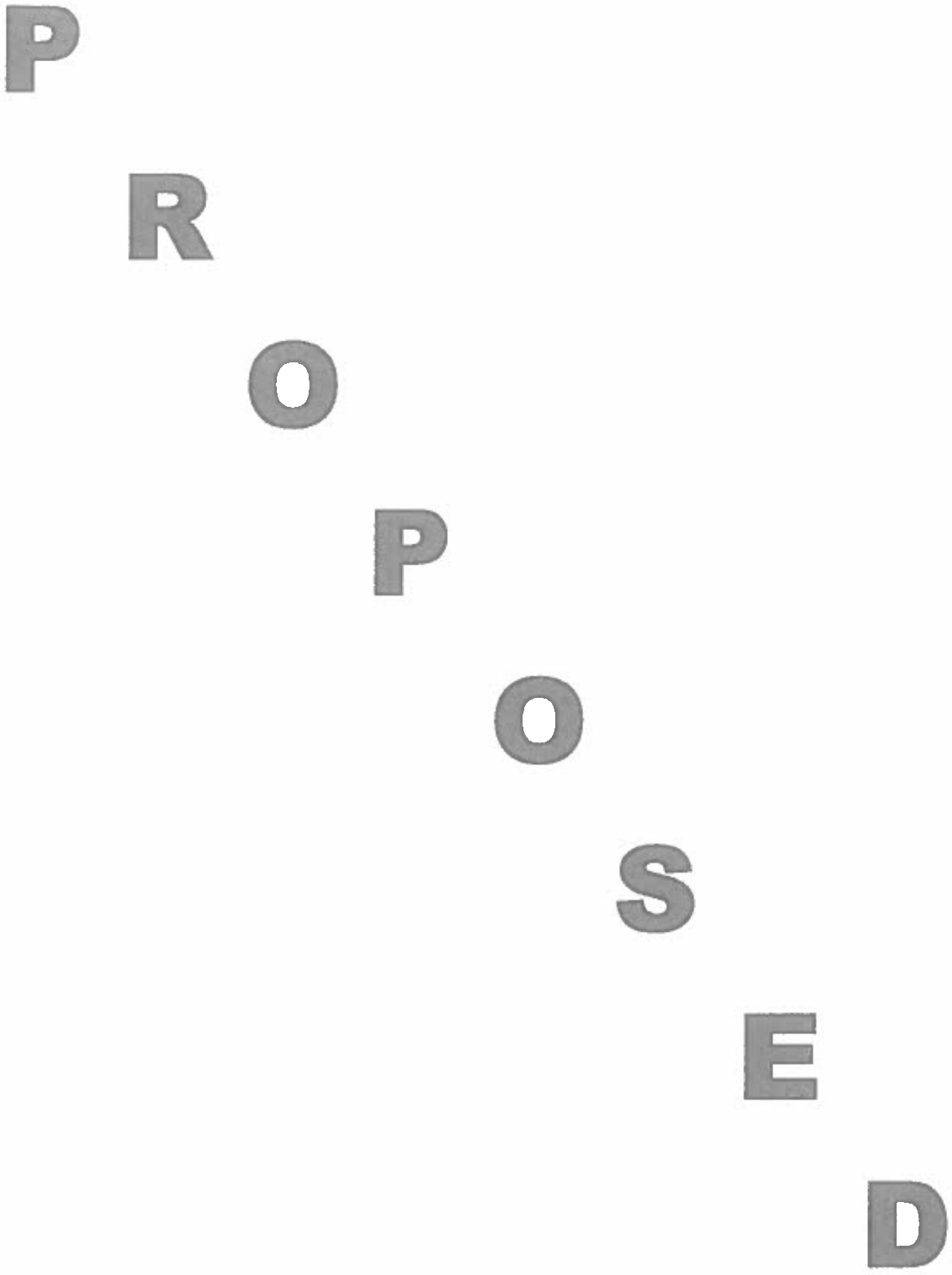
_____

_____

_____

_____ _____

Signature of health care provider Date


PROPOSED

Philomath School District 17J

Code: GCBDA/GDBDA-AR(3)(B)
Revised/Reviewed: 6/06/08
Orig. Code: GCBDA/GDBDA-AR(3)(B)

Sample Letter to Employee -- OFLA Leave

The following is a sample cover letter to an employee notifying the employee that the employer is treating a request for leave as a request for OFLA leave (either paid or unpaid) that will reduce the employee's OFLA leave entitlement. This letter should be mailed to the employee within two working days after the employee's request for the leave along with the OFLA notice form.

Dear Employee:

On ___(date)___ you advised the district that you were requesting a leave under the Oregon Family Leave Act (OFLA). Under our policy, leaves of absence that qualify for family and medical leave under state run concurrently with other types of leave such as sick leave, vacation leave, and short-term disability leave. OFLA cannot run concurrently with workers' compensatory leave.

We understand the purpose of your requested leave qualifies as family medical leave under state law. Accordingly, this letter is to notify you that the leave will be counted against your annual OFLA leave entitlement. Also attached is a form entitled OFLA Notice to Employee which contains other information for you regarding state family medical leave rights.

Sincerely,

Business Manager

Enclosure (OFLA Notice to Employee form)

Corrected 5/2/19

Philomath School District 17J

Code: GCBDA/GDBDA-AR(3)(B)
Revised/Reviewed:

Certification of Health Care Provider

Family Member's Serious Health Condition

To be Completed by the District:

The Family Medical Leave Act (FMLA) provides that a district may require an employee seeking FMLA leave protections because of a need for leave to care for a covered family member with a serious health condition to submit a medical certification issued by the health care provider of the covered family member. Employees may not be asked to provide more information than allowed under the FMLA regulations. The district will maintain records and documents relating to medical certification, recertifications or medical histories of the employee's family members, created for FMLA purposes, as confidential medical records in separate files from personnel files and in accordance with 29 C.F.R. § 1630.14(c)(1), if the Americans with Disabilities Act applies, and in accordance with 29 C.F.R. § 1635.9, if the Genetic Information Nondiscrimination Act applies.

District contact person: _____

Employee's job title: _____ Regular work schedule: _____

Employee's essential job functions: _____

_____

Check if job description is attached: ☐

Return this completed form on _____ (date) (must be at least 15 days after employee is notified of this requirement).

To be Completed by the Employee:

Complete the information below before giving this form to your family member or his/her medical provider. The return of this form is required to obtain or retain the benefit for FMLA protections. Failure to provide a complete and sufficient medical certification may result in a denial of your FMLA request.

Employee's name: _____
First Middle Last

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

_____
First Middle Last

If the family member is your child, please provide his/her date of birth: _____

Describe the care you will provide to your family member and estimate the leave needed to provide such care:

Employee signature _____ Date _____

To be Completed by Health Care Provider:

The employee listed above has requested leave under the FMLA to care for your patient. Answer fully and completely, all applicable parts below. Several questions seek a response as to the frequency or duration of a condition, treatment, etc. Your answer should be the best estimate based upon your medical knowledge, experience and examination of the patient. Be as specific as you can; terms such as "lifetime," "unknown," or "indeterminate" may not be sufficient to determine FMLA coverage. Limit your responses to the condition for which the patient needs leave. Do not provide information about genetic tests, as defined in 29 C.F.R. § 1635.3(f), C.F.R. § 1635.3(b). Extra space is provided, should you need it. Please be sure to sign the form on the last page.

Provider's name and business address: _____

Type of practice/medical specialty: _____

Telephone: (___) _____ Fax: (___) _____

Email: _____

Medical Facts

1. The approximate date the condition commenced: _____

   The probable duration of the condition: _____

   Was the patient admitted for an overnight stay in a hospital, hospice or residential medical care facility?
   ☐ Yes ☐ No If yes, dates of admission: _____

   List the dates(s) you treated the patient for their condition: _____

   Was medication, other than over-the-counter medication, prescribed? ☐ Yes ☐ No

   Will the patient need to have treatment visits at least twice per year due to the condition? ☐ Yes ☐ No

   Was the patient referred to other health care provider(s) for evaluation or treatment (e.g. physical therapist)?
   ☐ Yes ☐ No

   If yes, state the nature of such treatments and expected duration of treatment:

   _____

   _____

2. Is the medical condition pregnancy? ☐ Yes ☐ No

If yes, expected delivery date: _____

3. Describe other relevant medical facts, if any, related to the condition for which the employee seeks leave (such medical facts may include symptoms, diagnosis or any regimen of continuing treatment such as the use of specialized equipment):

_____

_____

_____

Amount of Leave Needed

When answering these questions, keep in mind that your patient's need for care from the employee seeking leave may include assistance with basic medical, hygienic, nutritional, safety or transportation needs, or the provision of physical or psychological care.

1. Will the patient be incapacitated for a single continuous period of time, including any time for treatment and recovery? ☐ Yes ☐ No

   If yes, estimate the beginning and ending dates for the period of incapacity: _____

   _____

   During this time, will the patient need care? ☐ Yes ☐ No

   Explain the care needed by the patient and why such care is medically necessary:

2. Will the patient require follow-up treatments, including any time for recovery? ☐ Yes ☐ No

   Estimate treatment schedule, if any, including the dates of any scheduled appointments and the time required for each appointment, including any recovery period: _____

   _____

   Explain the care needed by the patient, and why such care is medically necessary: _____

   _____

   _____

3. Will the patient require care on an intermittent or reduced schedule basis, including any time for recovery? ☐ Yes ☐ No

   Estimate the hours the patient needs care on an intermittent basis, if any:

   _____ hour(s) per day; _____ days per week from _____ through _____

   Explain the care needed by the patient, and why such care is medically necessary: _____

   _____

   _____

4. Will the condition cause episodic flare-ups periodically preventing the patient from participating in normal daily activities? ☐ Yes ☐ No

Based upon the patient's medical history and your knowledge of the medical condition, estimate the frequency of flare-ups and the duration of related incapacity that the patient may have over the next six months (e.g. one episode every three months lasting one to two days):

Frequency: _____ times per _____ week(s) _____ month(s)

Duration: _____ hours or _____ day(s) per episode

Does the patient need care during these flare-ups? ☐ Yes ☐ No

Explain the care needed by the patient, and why such care is medically necessary: _____

_____

_____

Additional Information (Identify the question number with your additional answer):

_____

_____

_____

_____

_____

_____ _____

Signature of health care provider Date

Corrected 5/2/19; Corrected 5/2/19

Philomath School District 17J

Code: GCBDA/GDBDA-AR(3)(C)
Revised/Reviewed:

Military Family Leave

Certification of Qualifying Exigency for Military Family Leave

Section 1: (To be completed by the district)

The Family Medical Leave Act (FMLA) and the Oregon Military Family Leave Act (OMFLA) provide that a district may require an employee seeking FMLA or OMFLA leave due to a qualifying exigency or due to notification of impending call to active duty or deployment to submit a certification. Employees may not be asked to provide more information than allowed under the FMLA or OMFLA regulations.

District Name and Address: _____

[Superintendent or designee] information: _____

Section 2: (To be completed by the employee)

Complete the information below fully and completely. The FMLA or OMFLA permits the district to require that you submit a timely, complete and sufficient certification to support a request for FMLA or OMFLA leave due to a qualifying exigency or due to notification of impending call to active duty or deployment. Several questions in this section seek a response as to the frequency or duration of the qualifying exigency. Be as specific as you can; terms such as "lifetime," "unknown" or "indeterminate" may not be sufficient to determine FMLA or OMFLA coverage. Your response is required to obtain a benefit. While you are not required to provide this information, failure to do so may result in a denial of your request for qualifying leave. The district must give you at least 15 calendar days to return this form to the district.

Employee's name: _____
First Middle Last

Name of covered military member on active duty or call to active duty status in support of a contingency operation:

_____
First Middle Last

Relationship of covered military member to you: _____

Period of covered military member's active duty: _____

A complete and sufficient certification to support a request for FMLA leave due to a qualifying exigency includes written documentation confirming a covered military member's active duty or call to active duty status in support of a contingency operation. Please check one of the following and attach the indicated document to support that the military member is on covered active duty or called to covered active duty status:

- ☐ A copy of the covered military member's active duty orders is attached.
- ☐ Other documentation from the military certifying that the covered military member is on active duty (or has been notified of an impending call to active duty).
- ☐ I have previously provided the district with sufficient written documentation confirming the covered military member's active duty or call to active duty status.

Part A: Qualifying Reason for Leave

1. Describe the reason you are requesting qualifying leave due to a qualifying exigency (include the specific reason you are requesting leave):

_____

_____

_____

2. Describe the reason you are requesting OMFLA leave (include the specific reason below, either a) an impending call or order to active duty, or b) impending leave from deployment):

_____

_____

3. A complete and sufficient certification to support a request for qualifying leave due to a qualifying exigency includes any available written documentation which supports the need for leave; such documentation may include a copy of a meeting announcement for information briefings sponsored by the military a document confirming the military member's Rest and Recuperation Leave; a document confirming an appointment with a third party, such as a counselor, school official or staff at a care facility; or a copy of a bill for services for the handling of legal or financial affairs. Is available written documentation supporting this request for leave attached? ☐ Yes ☐ No ☐ None available

Part B: Amount of Leave Needed

1. The approximate date the qualifying exigency or deployment commenced or will commence is:

_____.

The probable duration of such exigency or deployment is: _____

2. Will you need to be absent from work for a single continuous period of time due to the qualifying exigency or deployment? ☐ Yes ☐ No

If yes, estimate the beginning and ending dates for the period of absence: _____

3. Will you need to be absent from work periodically to address this qualifying exigency or deployment?
☐ Yes ☐ No
If yes, estimate the schedule of leave, including the dates of any scheduled meetings or appointments:

_____

_____

4. Estimate the frequency and duration of each appointment, meeting or leave event, including any travel time (i.e. one deployment-related meeting every month lasting four hours) (FMLA only):

Frequency: _____ times per _____ week(s) _____ month(s)

Duration: _____ hours or _____ day(s) per event

Part C: Third Party Certification

If leave is requested to meet with a third party (such as to arrange for childcare, to attend counseling, to attend meetings with school or childcare providers, to make financial or legal arrangements, to act as the covered military member's representative before a federal, state or local agency for purposes of obtaining, arranging or appealing military service benefits, or to attend any event sponsored by the military or military service organizations), a complete and sufficient certification includes the name, address and appropriate contact information of the individual or entity with whom you are meeting (i.e. either the telephone or fax number or email address of the individual or entity). This information may be used by the district to verify that the information contained on this form is accurate (FMLA only).

Name of individual: _____ Title: _____

Organization: _____

Address: _____

Telephone: (___) _____ Fax: (___) _____

Email: _____

Describe the nature of the meeting: _____

Part D: Employee Signature

I certify that the information I provided above is true and correct. (For OMFLA leave purposes, notice must be given by the employee within five business days of receiving an official notice.)

_____ _____

Signature of employee Date

Corrected 5/22/19

Philomath School District 17J

Code: GCBDA/GDBDA-AR(3)(D)
Revised/Reviewed: 2/18/14
Orig. Code: GCBDA/GDBDA-AR(3)(D)

Military Family Leave

~~Certification~~ for Serious Injury or Illness of Covered Servicemember for Military Family Leave

Notice and instructions to the district:

The Family Medical Leave Act (FMLA) provides that a district may require an employee seeking FMLA leave due to a serious injury or illness of a covered servicemember to submit a certification providing sufficient facts to support the request for leave. Employees may not be asked to provide more information than allowed under the FMLA regulations 29 C.F.R. § 825.310. The district will maintain records and documents relating to medical certification, recertifications or medical histories of employees or employees' family member, created for FMLA purposes, as confidential medical records in separate files from personnel files and in accordance with 29 C.F.R. § 1630.14(c)(1), if the Americans with Disabilities Act applies.

Section 1

Part A: Employee Information

Complete the employee and covered servicemember information below before giving this form to your family member or his/her medical provider.

_____

District Name and Address

Name of employee requesting leave to care for covered servicemember:

_____

First Middle Last

Name of covered servicemember for whom employee is requesting leave to care for:

_____

First Middle Last

Relationship of employee to covered servicemember requesting leave to care for:

☐ Spouse ☐ Parent ☐ Child ☐ Next of kin

Part B: Covered Servicemember Information

1. Is the covered servicemember a current member of the regular Armed Forces, the National Guard or Reserves, or a veteran? ☐ Yes ☐ No

   If a current servicemember, please provide the covered servicemember's military branch, rank and unit currently assigned to:

   _____

   _____

   If a qualifying veteran, when was the date of discharge? _____

Is the covered servicemember assigned to a military medical treatment facility as an outpatient or to a unit established for the purpose of providing command and control of members of the Armed Forces receiving medical care as outpatients (such as medical hold or warrior transition unit)? ☐ Yes ☐ No

If yes, provide the name of the medical facility or unit:

_____

2. Is the covered servicemember on the Temporary Disability Retired List (TDRL)? ☐ Yes ☐ No

Part C: Care to be Provided to the Covered Servicemember

Describe the care to be provided to the covered servicemember and an estimate of the leave needed to provide the care:

_____

_____

Section 2:

(For completion by a United States Department of Defense (DOD) Health Care Provider or a Health Care Provider who is either: (1) a United States Department of Veterans Affairs (VA) health care provider; (2) a DOD TRICARE network authorized private health care provider; (3) a DOD non-network TRICARE authorized private health care provider; or (4) a health care provider as defined in 29 C.F.R. § 825.125.)

If you are unable to make certain of the military-related determinations contained below in Part B, you are permitted to rely upon determinations from an authorized DOD representative (such as a DOD recovery care coordinator). Please ensure that Section 1 above has been completed before completing this section. Please be sure to sign the form on the last page.

Part A: Health Care Provider Information

Health care provider's name and business address:

_____

_____

Type of practice/medical specialty: _____

Please state whether you are either: (1) a DOD health care provider; (2) a VA health care provider; (3) a DOD TRICARE network authorized private health care provider; (4) a DOD non-network TRICARE authorized private care provider; or (5) a health care provider as defined in 29 C.F.R. § 825.125.

Telephone: (____) _____ Fax: (____) _____ Email: _____

Part B: Medical Status

1. Covered servicemember's medical condition is classified as (check one of the appropriate boxes):

☐ (VSI) Very Seriously Ill/Injured – Illness/Injury is of such a severity that life is imminently endangered. Family members are requested at the bedside immediately. (Please note this is an internal DOD casualty assistance designation used by DOD health care providers.)

☐ (SI) Seriously Ill/Injured – Illness/Injury is of such severity that there is cause for immediate concern, but there is no imminent danger to life. Family members are requested at bedside. (Please note this is an internal DOD casualty assistance designation used by DOD health care providers.)

☐ Other Ill/Injured – A serious injury or illness that may render the servicemember medically unfit to perform the duties of the member's office, grade, rank or rating.

☐ None of the above. (Note to employee: If this box is checked, you may still be eligible to take leave to care for a covered family member with a "serious health condition". If such leave is requested, you may be required to complete the form *Certification of Health Care Provider for Family Member's Serious Health Condition.*)

2. Was the condition for which the covered servicemember is being treated incurred in the line of duty on active duty in the Armed Forces? ☐ Yes ☐ No

   If no, did the condition exist before the beginning of active duty and aggravated by service in the line of duty while on active duty? ☐ Yes ☐ No

3. Appropriate date condition commenced: _____

4. Probable duration of condition and/or need for care: _____

5. Is the covered servicemember undergoing medical treatment, recuperation or therapy? ☐ Yes ☐ No
   If yes, please describe medical treatment, recuperation or therapy:

   _____

   _____

Part C: Covered Servicemember's Need for Care by Family Member

1. Will the covered servicemember need care for a single continuous period of time, including any time for treatment and recovery? ☐ Yes ☐ No
   If yes, estimate the beginning and ending dates for this period of time: _____

2. Will the covered servicemember require periodic follow-up treatment appointments? ☐ Yes ☐ No

   If yes, estimate the treatment schedule: _____

3. Is there a medical necessity for the servicemember to have periodic care for these follow-up treatment appointment?
   ☐ Yes ☐ No

4. Is there a medical necessity for the covered servicemember to have periodic care for other than scheduled follow-up treatment appointments (e.g. episodic flare-ups of medical conditions)? ☐ Yes ☐ No
   If yes, estimate the frequency and duration of the periodic care.

   _____

_____ _____

Signature of health care provider Date

Corrected 5/2/19

Philomath School District 17J

Code: GCBDA/GDBDA-AR(4)
Revised/Reviewed: 2/18/14
Orig. Code: GCBDA/GDBDA-AR(4)

FMLA/OFLA Eligibility Notice to Employee

DATE: _____

TO: _____
(Employee's name)

FROM: _____
(Name of appropriate employer representative)

SUBJECT: Request for FMLA and/or OFLA Leave

On _____ (date) you notified us of your need to take family/medical leave due to:

1. _____ The birth of your child or the placement of a child with you for adoption or foster care;

2. _____ A serious health condition that makes you unable to perform the essential functions of your job;

3. _____ A serious health condition of your ☐ spouse[1], ☐ child (including the biological, grandchild, adopted or foster child or stepchild of an employee or a child with whom the employee is or was in a relationship of "in loco parentis"), ☐ parent (biological parent of an employee or an individual who stood "in loco parentis" to an employee when the employee was a child), ☐ grandparent (OFLA leave only), ☐ parent-in-law or the parent of an employee's registered domestic partner (OFLA leave only), ☐ custodial parent, ☐ noncustodial parent, ☐ adoptive parent, ☐ foster parent for which you are needed to provide care;

4. _____ An illness or injury to your child which requires home care but is not a serious health condition (OFLA leave only);

5. _____ A qualifying exigency arising from a spouse, child or parent in the Armed Forces on covered active duty, or in the National Guard or Reserves on covered active duty;

6. _____ Your spouse has been notified of an impending call to active duty, has been ordered to active duty or has been deployed or on leave from deployment;

7. _____ A serious illness or injury, incurred in the line of duty, of a covered service member who is your spouse, child, parent or next of kin;

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

You notified us that you need this leave beginning on _____ (date) and that you expect leave to continue until on or about _____ (date). The FMLA requires that you notify the district as soon as possible if dates of scheduled leave changes or are extended, or were initially unknown.

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[1] "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.

Except as explained below, you have a right under the FMLA and/or OFLA for up to 12 workweeks of unpaid leave in a 12-month period for the reasons listed above.[2] The district will use [the calendar year] [any fixed 12-month "leave year"] [the 12-month period measured forward from the date the employee's leave begins] [a "rolling" 12-month period measured backward from the date the employee uses any family medical leave]. FMLA leave and OFLA leave generally run concurrently. In order to care for an injured service member, you are entitled to up to 26 weeks of leave in a single 12-month period.

Also, your health benefits under FMLA and OFLA must be maintained during any period of unpaid leave under the same conditions as if you continued to work, including you continuing to pay the same portion of the premiums you currently pay. You will be reinstated to the same position, or in some cases under state or federal law, to an equivalent position.

If you do not return to work following FMLA and/or OFLA leave for a reason other than: (1) the continuation, recurrence or onset of a serious health condition which would entitle you to FMLA and/or OFLA; or (2) other circumstances beyond your control, you may be required to reimburse the district for health insurance premiums paid on your behalf during your FMLA and/or OFLA leave.

This is to inform you that *(check appropriate boxes, explain where indicated)*:

1. You are ☐ eligible ☐ not eligible for leave under ☐ FMLA ☐ OFLA ☐ both FMLA and OFLA.

2. The requested leave may be counted against your annual ☐ FMLA leave entitlement ☐ OFLA leave entitlement ☐ FMLA and OFLA leave entitlements.

3. You ☐ will ☐ will not be required to furnish a medical certification of a serious health condition. If required, you must furnish the certification by _____ (date) (must be at least 15 days after you are notified of this requirement).

4. You may elect to substitute accrued paid leave for unpaid FMLA leave. We ☐ will ☐ will not require that you substitute accrued paid leave for unpaid FMLA and/or OFLA leave. If paid leave will be used, the following conditions will apply: (*Explain*)

5. a. If you normally pay a portion of the premiums for your health insurance, these payments will continue during the period of FMLA and/or OFLA leave. Arrangements for payment have been discussed with you and it is agreed that you will make premium payments as follows: (*Set forth dates, e.g., the 10th of each month or pay periods, etc., that specifically cover the agreement with the employee.*)

5. b. You have a minimum ☐ 30-day ☐ Other: _____ (*indicate longer period, if applicable*) grace period in which to make premium payments. If payment is not timely made, your group health insurance may be canceled. We will notify you in writing at least 15 days before the date that your health coverage will lapse. At our option, we may also pay your share of the premiums during your FMLA and/or OFLA leave as provided by Board policy and/or collective bargaining agreement, and recover these payments from you upon your return to work. We ☐ will ☐ will not pay your share of health insurance premiums while you are on FMLA and/or OFLA leave.

[2] Oregon Military Family Leave Act allows for 14 days of leave per deployment.

5. c. We ☐ will ☐ will not do the same with other benefits (e.g., life insurance, disability insurance, etc.) while you are on FMLA and/or OFLA leave. If we do pay your premiums for other benefits, when you return from leave you ☐ will ☐ will not be expected to reimburse us for the payments made on your behalf.

5. d. Except as noted above, in the event you do not return to work for the district after your FMLA and/or OFLA leave, and the district has paid your share of benefit premiums, you ☐ will ☐ will not be responsible for reimbursing the district the amount paid on your behalf with the exceptions noted in C.F.R. § 104 (c)(2)(B) of the FMLA.

6. ☐ You will be required to present a fitness-for-duty certification prior to being restored to employment following leave for your own serious health condition. If such certification is required but not received, your return to work may be delayed until the certification is provided. A list of essential functions for your position is attached. The fitness-for-duty certification must address your ability to perform these functions.

☐ You will not be required to present a fitness-for-duty certification prior to being restored to employment following leave for your own serious health condition.

7. a. You ☐ are ☐ are not a "key employee" as described in C.F.R. § 825.218 of the FMLA regulations. If you are a "key employee," reinstatement to employment may be denied following FMLA leave on the grounds that such restoration will cause substantial and grievous economic injury to the district. (FMLA leave only.)

7. b. We ☐ have ☐ have not determined that restoring you to employment at the conclusion of FMLA leave will cause substantial and grievous economic harm to us. (FMLA leave only.) (*Explain (a) and/or (b) below.*)

8. While on FMLA and/or OFLA leave you ☐ will ☐ will not be required to furnish us with periodic reports every _____ (*indicate interval of periodic reports, as appropriate for the particular leave situation*) of your status and intent to return to work. If the circumstances of your leave change and you are able to return to work earlier than the date indicated on this form, you ☐ will ☐ will not be required to notify us at least two workdays prior to the date you intend to report for work.

9. You ☐ will ☐ will not be required to furnish recertification relating to a serious health condition. (FMLA leave only.) (*Explain below, if necessary, including the interval between certifications as prescribed in C.F.R. § 825.308 of the FMLA regulations.*)

10. You are notified that all leave taken for the purposes of the death of a family member, counts toward the total period of authorized family leave.

Corrected 5/7/19

Philomath School District 17J

Code: GCBDA/GDBDA-AR(5)
Revised/Reviewed: 2/18/14
Orig. Code: GCBDA/GDBDA-AR(5)

Medical Certification Form

(To be completed by health-care provider)

Certification of Health-care Provider
(Family and Medical Leave Act of 1993)

1. Employee's Name: _____

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

3. The attached sheet describes what is meant by a "serious health condition" or a "serious illness or injury of a covered service member" under the Family and Medical Leave Act. Does the patient's condition[1] qualify under any of the categories described? If so, please check the applicable category.

   (1) _____ (2) _____ (3) _____ (4) _____ (5) _____ (6) _____

   None of the above _____

4. 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:

5a. State the approximate date the condition commenced and the probable duration of the condition (and also the probable duration of the patient's present incapacity[2] if different):

5b. 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 described in Item 6 below):

   If yes, give the probable duration:

5c. If the condition is a chronic condition (condition #4) or pregnancy, state whether the patient is presently incapacitated and the likely duration and frequency of episodes of incapacity:

6a. If additional treatments will be required for the condition, provide an estimate of the probable number of such treatments.

---

[1]Here and elsewhere on this form, the information sought relates only to the condition for which the employee is taking FMLA leave.

[2] "Incapacity," for purposes of FMLA, is defined to mean inability to work, attend school or perform other regular daily activities due to the serious health condition, treatment therefor or recovery therefrom.

If the patient will be absent from work or other daily activities because of a treatment on an intermittent or part-time basis, also provide an estimate of the probable number and interval between such treatments, actual or estimated dates of treatment if known and period required for recovery if any:

6b. 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.

6c. 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):

7a. If medical leave is required for the employee's absence from work because of the employee's own condition (including absences due to pregnancy or a chronic condition), is the employee unable to perform work of any kind? _____

7b. 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 (the employee or the employer should supply you with information about the essential job functions)? _____ If yes, please list the essential functions the employee is unable to perform:

7c. If neither 7a. nor 7b. applies, is it necessary for the employee to be absent from work for treatment? _____

8a. If 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? _____

8b. If no, would the employee's presence to provide psychological comfort be beneficial to the patient or assist in the patient's recovery? _____

8c. If the patient will need care only intermittently or on a part-time basis, please indicate the probable duration of this need:

9. Was the serious illness or injury sustained in the line of duty, while on active duty, that may render the person medically unfit to perform the duties of the person's office, grade, rank, or rating?

(Signature of Health-care Provider) (Type of Practice)

(Address) (Telephone Number)

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 Signature) (Date)

A "serious health condition" means an illness, injury, impairment or physical or mental condition of an employee or family member that involves one of the following:

1. **Hospital Care**

   Inpatient care (i.e., an overnight stay) in a hospital, hospice or residential medical care facility, including any period of incapacity or subsequent treatment in connection with or consequent to such inpatient care.

2. **Absence Plus Treatment**

   A period of incapacity of more than three consecutive calendar days (including any subsequent treatment or period of incapacity relating to the same condition) that also involves:

   a. Treatment[3] two or more times by a health-care provider, by a nurse or physician's assistant under direct supervision of a health-care provider or by a provider of health-care services (e.g., physical therapist) under orders of, or on referral by, a health-care provider; or
   b. Treatment by a health-care provider on at least one occasion which results in a regimen of continuing treatment[4] under the supervision of the health-care provider.

3. **Pregnancy**

   Any period of incapacity due to pregnancy or for prenatal care.

4. **Chronic Conditions Requiring Treatments**

   A chronic condition which:

   a. Requires periodic visits for treatment by a health-care provider or by a nurse or physician's assistant under direct supervision of a health-care provider;
   b. Continues over an extended period of time (including recurring episodes of a single underlying condition); and

[3] Treatment includes examinations to determine if a serious health condition exists and evaluations of the condition. Treatment does not include routine physical examinations, eye examinations or dental examinations.

[4] A regimen of continuing treatment includes, for example, a course of prescription medication (e.g., an antibiotic) or therapy requiring special equipment to resolve or alleviate the health condition. A regimen of treatment does not include the taking of over-the-counter medications such as aspirin, antihistamines or salves; or bed-rest, drinking fluids, exercise and other similar activities that can be initiated without a visit to a health-care provider. An exception to this definition of regimen could occur when an employee suffers from a minor illness generally treated with over-the-counter medication, bed rest and intake of fluids so long as the employee is incapacitated for more than three days and is under continuing treatment by a health-care provider for the specific ailment.

c. May cause episodic rather than a continuing period of incapacity (e.g., asthma, diabetes, epilepsy, etc.).

5. Permanent/Long-term Conditions Requiring Supervision

A period of incapacity which is permanent or long-term due to a condition for which treatment may not be effective. The employee or family member must be under the continuing supervision of, but need not be receiving active treatment by, a health-care provider. Examples include Alzheimer's, a severe stroke or the terminal stages of a disease.

6. Multiple Treatments (Nonchronic Conditions)

Any period of absence to receive multiple treatments (including any period of recovery therefrom) by a health-care provider or by a provider of health-care services under orders of, or on referral by, a health-care provider, either for restorative surgery after an accident or other injury, or for a condition that would likely result in a period of incapacity of more than three consecutive calendar days in the absence of medical intervention or treatment, such as cancer (chemotherapy, radiation, etc.), severe arthritis (physical therapy), kidney disease (dialysis).

A "serious illness or injury of a covered service member" means an injury or illness incurred by the member in the line of duty, while on active duty in the Armed Forces that may render the member medically unfit to perform the duties of the member's office, grade, rank, or rating.

DELETE

Philomath School District 17J

Code: GCBDA/GDBDA-AR(6)
Revised/Reviewed:

Designation Notice – FMLA/OFLA

Leave covered under the Family and Medical Leave Act (FMLA) and/or Oregon Family Leave Act (OFLA) must be designated as FMLA and/or OFLA-protected, and the district must inform the employee of the amount of leave that will be counted against the employee's FMLA and/or OFLA leave entitlement.

In order to determine whether leave is covered under the FMLA and/or OFLA, the district may request that the leave be supported by a physician's certification. If the certification is incomplete or insufficient, the district will state in writing what additional information is necessary to make the certification complete and sufficient.

Employee Name: _____ Date: _____

We have reviewed your request for leave under the FMLA and/or OFLA and any supporting documentation that you have provided. We received your most recent information on _____.

Please be advised:

- ☐ Your request is approved for FMLA. All leave taken for this reason will be designated as FMLA leave.
- ☐ Your request is approved for FMLA and OFLA. This designation of leave will run concurrently.
- ☐ Your request is approved for OFLA. All leave taken for this reason will be designated as OFLA leave.

The FMLA and/or OFLA requires that you notify us as soon as practicable if dates of scheduled leave change or are extended, or were initially unknown. Based on the information you have provided to date, we are providing the following information about the amount of time that will be counted against your entitlement:

- ☐ Provided there is no deviation from your anticipated leave schedule, the following number of hours, days or weeks will be counted against your leave entitlement:

_____

- ☐ Because the leave you requested will be rescheduled, it is not possible to provide the hours, days or weeks that will be counted against your FMLA and/or OFLA entitlement at this time. You have the right to request this information once in a 30-day period (if leave was taken in the 30-day period).

Please be advised (check if applicable):

- ☐ You have requested to use paid leave during your FMLA and/or OFLA leave. Any paid leave taken for this reason will count against your FMLA and/or OFLA leave entitlement.
- ☐ We are requiring you to substitute or use paid leave during your FMLA and/or OFLA leave.

☐ You will be required to present a fitness-for-duty certification to be reinstated to your position. If such certification is not timely received, your return to work may be delayed until certification is provided. The Fitness-for-Duty Certification form is attached, please have your medical provider complete this form prior to the termination of your leave. A list of the essential functions of your position ☐ is ☐ is not attached. If attached, the fitness-for-duty certification must address your ability to perform these functions:

_____

☐ Additional information is needed to determine if your FMLA and/or OFLA leave request can be approved.

_____

☐ The certification you have provided is incomplete and insufficient to determine whether the FMLA and/or OFLA applies to your leave procedures. You must provide the following information no later than _____ (date) (at least 15 calendar days), unless it is not practicable under the particular circumstances despite your diligent good faith efforts, or your leave may be denied. The information needed to make the certification complete and sufficient is[1]:

_____

_____

☐ We are exercising our right to have you obtain a second or third opinion medical certification at our expense, and we will provide further details at a later time.

****

☐ Your FMLA leave request is NOT APPROVED.

☐ The FMLA does not apply to your leave request.

☐ You have exhausted your FMLA leave entitlement in the applicable 12-month period. (Note: Federal Military Family Leave is on a separate 12-month period.)

☐ Your OFLA leave request is NOT APPROVED.

☐ The OFLA does not apply to your leave request.

☐ You have exhausted your OFLA leave entitlement in the applicable 12-month period.

Corrected 5/2/19

PROPOSED

[1] If you fail to provide a complete and sufficient certification by the due date, we may (a) delay the commencement of your leave; or (b) withdraw any designation of FMLA leave, in which case your leave of absence may be unauthorized and subject to discipline, up to and including termination.

Philomath School District 17J

Code: GCBDA/GDBDA-AR(7)
Revised/Reviewed:

Fitness-for-Duty Certification

[NOTE: THESE INSTRUCTIONS ARE NOT INTENDED TO BE INCLUDED WITH THE CERTIFICATION TO THE EMPLOYEE – DELETE THIS PARAGRAPH PRIOR TO REVIEW AND POSTING FOR USE. ***Instructions for use of this sample form:*** *In order to condition an employee's return to work for the employee's own serious health condition on a Fitness-for-Duty Certification form, the district must have notified the employee in the Designation Notice that a fitness-for-duty certification would be required before returning to work. If the district did not require a fitness-for-duty certification in the Designation Notice, once an employee comes back, if the district has concerns (based on evidence, not speculation) about the employee's ability to perform the job, the district can get a fitness-for-duty certification based on the Americans with Disabilities Act Amendments Act (ADAAA), rather than FMLA and OFLA. Under OFLA, the district cannot obtain a second opinion for fitness-for-duty certification, and fitness-for-duty certifications must be sought pursuant to uniformly applied policy. The district must pay any out-of-pocket expenses paid to obtain a fitness-for-duty examination. This is a sample fitness-for-duty certification.*]

To: _____ Date: _____

From: _____

Subject: Fitness-for-Duty Certification

Family and medical leave for your own serious health condition ends on (date) _____. Prior to returning to work you must provide a Fitness-for-Duty Certification verifying whether you are able to return to work, if you have any job-related restrictions and the duration of any restrictions. Please take this Fitness-for-Duty Certification to your health care provider for completion. The district will use this Fitness-for-Duty Certification to determine if you are able to return to work after your leave.

Return the completed Fitness-for-Duty Certification to the district prior to the end of your Family and Medical Leave or by (date) _____.

.....

Fitness-for-Duty Certification

Health Care Provider Completes this Section

Instructions: Please complete all sections in order for the district to determine if the employee is able to return to duty. The employee's position description or a list of essential duties (district specifies which) is attached to this form.

1. The employee is able to return to work full-time without restrictions: ☐ Yes ☐ No

   a. If yes, list the effective date: _____.
   b. If no, complete the following:

      (1) The employee will be able to return to work with no limitation on (date) _____.
      (2) I certify that from (date) _____ to (date) _____ the above named employee will be:

         (a) Unable to perform the physical requirements of their work; or
         (b) Is medically incapacitated: ☐ Totally ☐ Partially**

**If partially medically incapacitated, complete the following:

(c) Number of hours per day employee is able to work: _____.
(d) Number of days per week employee is able to work: _____.

(3) List any restrictions on the employee's work: _____

_____

_____

_____

_____ _____
Printed name of health care provider Type of practice

_____ _____
Signature of health care provider Date

Health care provider: Please return the completed form to the employee/patient.

Attached: Position description/description of essential duties (district specifies which).

Corrected 5/2/19

PROPOSED