SOUTHWESTERN OREGON COMMUNITY COLLEGE
REQUEST FOR FAMILY AND MEDICAL LEAVE (FMLA and/or OFLA)

Name____________________________________ Today's Date________________________

Job Title_________________________________ Department ________________________

Employment Classification: ___Faculty ___ Classified ___ MASSC
Status: ___ Full-time ___ Part-time >24 hours per week ___Part-time < 24 hrs/ week
Date of Hire ____
Have you taken a family leave in the past 12 months? Yes___ No___

Where the need for 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.

I request family or medical leave for one or more of the following reasons:

_____ 1. Birth of my child and/or in order to care for him or her.
Expected date of birth_______________ Actual date of birth_______________
(if known)
Leave to start_____________________ Expected return date_____________

_____ 2. Placement of a child with me for adoption or foster care.
Age of child______________________ Date of placement_______________
Leave to start_____________________ Expected return date_____________

_____ 3. To care for my spouse, child, parent or parent-in-law with a serious health condition.
Leave to start_____________________ Expected return date_____________
Please check one: Spouse___ Child___ Parent___ Parent-in-law___ *(OFLA)*
Name and address of relation:____
____
Describe serious health condition:____

_____ 4. For my own serious health condition which prevents me from performing my essential job functions.
Leave to start_____________________ Expected return date_____________
Describe serious health condition:____
____

Regarding #3 or #4 above, if you are requesting intermittent or reduced schedule leave (fewer work days each week or fewer hours per day) please describe schedule of when you will be unavailable for work. (Intermittent and reduced schedule leave following the birth or placement of a child for adoption or foster care is subject to employer approval.)
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_____ 5. 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.

_____ 6. To take time to be with my spouse, son, daughter or parent who is on active military duty or has been notified of an impending call to active military duty status, in support of a contingency operation.

_____ 7. To care for my spouse, son, daughter, parent, or next of kin, a covered service member, who is recovering from a serious illness or injury sustained in the line of duty on active duty.

I understand that a physician's certification may be required to support a request for family and medical leave. In addition, a fitness for duty certification will be required before reinstatement following leave taken for my own serious health condition.

I understand that FMLA and/or OFLA leave is unpaid, but that I may use accrued paid leave for the FMLA and/or OFLA leave period. Furthermore, I understand that I will be required to use accrued sick leave, personal leave and floating holiday while on FMLA and/or OFLA leave in accordance with applicable collective bargaining agreements and/or administrative policies. Federal and state family leave may be applied concurrently, consistent with state and federal laws.

If my request for FMLA and/or OFLA leave is approved, it is my understanding that without an authorized extension, I must report to duty on the first workday 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 that the College may terminate my employment.

I authorize the College to deduct from my paycheck(s) any employee contributions for health insurance and/or other approved deductions that remain unpaid after my leave, consistent with state and/or federal law. I understand that if I exhaust all of my paid leave and continue on unpaid FMLA and/or OFLA leave, I will be required to pay the employee portion of my health insurance premium that is normally payroll deducted from my earnings.

Employee's Signature________________________________ Date Submitted_________________

Date Received in Human Resources___________________ Received by ___________________

For Human Resources Office Use Only:

Response Sent ____________________________

Med Cert Sent ____________________________

Med Cert Due ____________________________

Med Cert Rec'd ____________________________

Request Status ___ approved ___ not approved

FMLA Status ___ absences are protected ___ insufficient documentation from employee; absences are not protected

Amount of FMLA available ___________________________
(see individual worksheet)

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