

**CONFIDENTIAL**

**CLACKAMAS COUNTY  
FAMILY AND MEDICAL LEAVE REQUEST FORM**

Please Type or Print

**EMPLOYEE INFORMATION**

NAME	EMPLOYEE ID
ADDRESS	DEPARTMENT
CITY	WORK PHONE
STATE ZIP	DATE HIRED
HOME PHONE	WEEKLY WORK SCHEDULE

**REASON FOR REQUESTED LEAVE**

- Care for newborn, adopted or foster child.
- Care for my own serious health condition, including pregnancy,
- Care for a family member with a serious health condition. Specify relationship \_\_\_\_\_
- Bereavement leave following death of a family member. Specify relationship \_\_\_\_\_
- Related to deployment of family member in the military. Specify relationship \_\_\_\_\_

DATES OF LEAVE: FROM: \_\_\_\_\_ TO: \_\_\_\_\_

If you have taken leave (paid or unpaid) for any of the above reasons in the previous 12 months, please list the dates:

Are you requesting leave on an intermittent schedule (reduced hours per day and/or days per week)? If yes, please list dates and hours when you anticipate you will be unavailable for work, if known. (*Attach additional sheets if needed.*)

Name of doctor/health care provider \_\_\_\_\_

**EMPLOYEE ACKNOWLEDGEMENT**

- I understand that I must have the *Medical Certification by Physician or Practitioner* form completed and returned within 15 days.
- I agree I will not work for another employer while on leave.
- If leave is for my own serious health condition, I understand that I may not return to work until I provide a completed *Release to Return to Work* form.
- If using leave on an intermittent basis, I understand that it will be my responsibility to notify my supervisor when absences are due to FML reasons.
- I agree that while I am on leave, I will continue to pay my share of benefits premiums, if applicable, unless I choose to discontinue coverage.
- I understand that any period of paid disability leave may count toward Family and Medical Leave.
- I agree that if I choose not to return to work at the end of the leave, I will reimburse the County for the cost of County-provided health benefits during my leave. However, if I am unable to return because of the continuation, recurrence or onset of a serious health condition or because of other circumstances beyond my control, this provision will not apply.
- If I am unable to return to work at the end of the leave period because of my own or my family member's serious health condition, I will provide medical certification from the appropriate health care provider. This statement must show that on the date my leave expired I was unable to perform the functions of my position or that I still am needed to care for my family member because he/she has a serious health condition.
- I understand that if I do not return to work at the end of my approved leave time, my employment may be terminated by the County as of the date my leave expired and that I have no reinstatement rights.

Employee's Signature \_\_\_\_\_ Date \_\_\_\_\_

**COMPLETE BOTH SIDES OF THIS FORM**

NAME:	EMPLOYEE ID
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**REQUESTED USE OF ACCRUED PAID LEAVE – SPECIFY HOW YOUR ACCRUED PAID LEAVE IS TO BE USED**

	<u>Order for Use of Leave</u>	<u># of Hours to Retain</u>
Sick Leave*	_____	_____
Vacation**	_____	_____
Comp Time	_____	_____
Personal Holiday	_____	_____
Leave Without Pay	_____	_____

\* Employees on a **medical leave** of absence to care for themselves or an ill family member are **required to use all accrued sick leave** prior to using other accrued paid leave or being placed on leave without pay. Use of all accrued sick leave is also required to meet eligibility for disability payments. \*\* **Employees' Association** and **FOPPO** members **must use vacation after sick leave** becomes exhausted when sick leave usage is required. Up to 40 hours of vacation may be retained before unpaid leave is used.

**SUPERVISOR ACKNOWLEDGEMENT**

I have reviewed this request and acknowledge the leave requiring time away from his/her position. I understand DES retains full authority in the determination of qualification of this request.

Supervisor's Name \_\_\_\_\_ Date \_\_\_\_\_

Please Print

Supervisor's Signature \_\_\_\_\_

**THIS FORM MUST BE FORWARDED TO THE RISK/BENEFITS DIVISION. THIS FORM MAY NOT BE REPRODUCED OR RETAINED IN ANY MANNER BY THE EMPLOYEE'S DEPARTMENT. ALL INFORMATION CONTAINED ON THIS FORM SHALL REMAIN CONFIDENTIAL AND THE FORM RETAINED IN THE EMPLOYEE'S FML FILE IN THE DEPARTMENT OF EMPLOYEE SERVICES.**

**DEPARTMENT OF EMPLOYEE SERVICES REVIEW**

Leave granted.

Entitlement Dates:	Begin	End
FMLA/OFLA Medical Leave	_____	_____
OFLA Parental Leave	_____	_____

Leave denied. Employee not eligible for Family and Medical Leave. (Explain)

\_\_\_\_\_

Comments:

\_\_\_\_\_

\_\_\_\_\_

DES Human Resources Analyst \_\_\_\_\_ Date \_\_\_\_\_