**Employee Request for Family & Medical Leave (FMLA)**
**and/or Oregon Family Leave (OFLA)**

Federal Family Medical Leave ("FMLA") is available to employees who have completed at least one (1) year of service and who have worked at least 1,250 hours in the previous year. Generally, Oregon Family Leave ("OFLA") is available to employees who have completed at least 180 days of employment, averaging at least 25 hours per week.

You must make a request for leave 30 days prior to the anticipated commencement of leave unless an emergency exists. In any event, you must provide reasonable advance notice of the need for leave. Leave may be delayed or reduced if proper notice is not given. If leave is approved for FMLA/OFLA, you must attempt to schedule leave to be as least disruptive to Friendsview.

***Please complete the front and back sides of this form and return to the HR Department.***

Name (Print): _____ Date: _____

I request family or medical leave for one or more of the following reasons[1] (**Please check the appropriate box.** If you are unsure, check definitions on the back page or check with the HR department.):

- ☐ My serious health condition—FMLA, OFLA;
- ☐ My pregnancy (includes morning sickness, bed rest, prenatal care, childbirth, and recovery)—FMLA, OFLA;
- ☐ Care for my newborn, newly adopted or newly placed foster child under age 18 (unless incapable of self-care due to disability)—FMLA, OFLA;
- ☐ Care for my family member (child, parent, legal spouse)) with a serious health condition—FMLA, OFLA;
- ☐ Care for my parent-in-law, grandparent, grandchild, or same-sex domestic partner with a serious health condition—OFLA;
- ☐ Care for my sick child who does not have a serious health condition, but requires home care—OFLA;
- ☐ A "qualified exigency" arising out of a spouse, son, daughter or parent's active duty or call to active duty in National Guard or Reserves—FMLA; or
- ☐ Care for a qualified family member who is ill or injured incurred in the line of duty on active duty—FMLA.

If the leave is for a family member, please list name & relationship to you: _____

_____

Is this a previously approved FMLA/OFLA qualifying condition? ☐ Yes ☐ No

Leave to start_____ Expected return date: _____

[1] Medical certification and/or fitness-for-duty certification may be required before leave is approved. For sick child leave, medical certification may be required after three days of leave.

**SIGNATURE OF EMPLOYEE**

**(REQUIRED FOR ANY KIND OF MEDICAL TIME OFF which falls under FMLA/OFLA LEAVE)**

- I understand that it is my **SOLE** responsibility to provide the appropriate medical certification outlined in the Company's policies in most circumstances **PRIOR TO** beginning and returning from my leave of absence.
- I understand that if I do not provide the appropriate medical certification to the Human Resources Department, my leave may be delayed, my OFLA leave allowance may be shortened, or my leave may be considered unprotected and my absence may be treated as unexcused under the Company's attendance rules.
- I understand that I **MAY NOT** be allowed to return to work until I submit appropriate medical certification to the Human Resources Department.
- I have read the Family and Medical Leave Policy, along with the definitions below.

Employee Signature: _____ Date: _____

Address: _____

Phone # _____ Email address: _____

**DEFINITION OF TERMS**

**"Serious health condition"** means an illness, injury, impairment or physical or mental condition:

- That requires in-patient care in a medical care facility such as a hospital, hospice or residential facility such as a nursing home.
- That the treating health care provider judges to pose an imminent danger of death, or that is terminal in prognosis with a reasonable possibility of death in the near future.
- That requires constant or continuing care (such as home care administered by a health care professional).
- That involves any period of incapacity or disability due to pregnancy or childbirth or period of absence for prenatal care.
- That results in a period of incapacity or treatment for a chronic serious health condition that requires periodic visits for treatment by a health care provider, continues over an extended period of time, and may cause episodic rather than a continuing period of incapacity (e.g., asthma, diabetes, or epilepsy).
- That involves a period of incapacity. Incapacity is the inability to perform at least one essential job function, or to attend school or perform regular daily activities for more than three consecutive calendar days and any subsequent required treatment or recovery period relating to the same condition. This incapacity must involve two or more treatments by a health care provider or one treatment plus a regimen of continuing care.
- That involves permanent or long-term incapacity due to a condition for which treatment may not be effective, such as Alzheimer's disease, a severe stroke or terminal stage of a disease. The employee or family member must be under the continuing care of a health care provider but need not be receiving active treatment.
- That involves multiple treatments for restorative surgery or for a condition that would likely result in a period of incapacity of more than three days in the absence of medical intervention or treatment (such as chemotherapy for cancer, physical therapy for arthritis, or dialysis for kidney disease).

(HR Only) Date Received/HR Initials: _____