

Complete both Section A (if required by your department) and B of this form in accordance with the Collective Bargaining Agreement whenever you are requesting leave.

Name: _____ UO ID# _____ Date _____

I hereby request leave from _____ (date)/ _____ (time) to _____ (date)/ _____ (time)

A. WHAT TYPE OF LEAVE ARE YOU REQUESTING? (complete all that apply)

VACATION	Hours: _____	or Days: _____	Notes: _____
SICK	Hours: _____	or Days: _____	
COMPENSATORY	Hours: _____	or Days: _____	
PERSONAL	Hours: _____	or Days: _____	
GOVERNOR'S LEAVE WITHOUT PAY	Hours: _____	or Days: _____	

APPROVED: _____ DENIED: _____

Reason for denial (circle one):

1. Did not meet contractual requirements for advance notice.
2. Workload too great.
3. Other staff members have already requested time off.
4. Other: _____

B. WHAT IS THE REASON FOR THE LEAVE YOU ARE REQUESTING? - (Check all that apply)

Vacation Military Leave Jury Duty Personal Business Health Condition (**check one of the following**)

1. Your minor illness or your immediate family/household's minor illness (if child under 18 years of age, check #5 below) (minor illness does not meet the definition of serious health condition shown on back.)

2. **Your serious health condition** (FMLA/OFLA certification required) – must meet one or more of the definitions listed on back.

3. Family member:

son (under 18) daughter (under 18) parent (not parent in-law) legal spouse
with a serious health condition which meets one or more of the definitions listed on back
(FMLA/OFLA certification required)

4. Family member (eligible for OFLA only):

parent-in-law same-gender domestic partner adult child (18 or older) grandparent/grandchild
with a serious health condition which meets one or more of the definitions listed on back
(FMLA/OFLA certification required)

5. Child requiring care for a non-serious health condition for any duration of time (only one or no treatments from a health care provider) **OFLA only**
(FMLA/OFLA certification NOT required)

6. Care for a newborn child FMLA/OFLA Date of Birth _____
 Placement of a foster child FMLA/OFLA Date of Placement _____
 Adoption of child FMLA/OFLA Date of Adoption _____

Do you have a spouse who works for the State of Oregon who is also requesting time off? Yes No

Does your reason for FMLA/OFLA require an intermittent schedule? Yes** No

If 'yes' and you are unable to provide your schedule at this time, you must submit this form each time you use leave.

**** The regulations say employees taking leave for the birth, placement or adoption of a child are required to take the leave all at once unless the employer elects to grant intermittent or reduced hour leave within a set time frame. Check with your supervisor. Your leave must be taken within 12 months after the birth or placement for adoption or foster care.**

IMPORTANT: If you checked reason #2, 3, 4 or 6 in this text box as your reason for leave, please contact Human Resources immediately. The leave may qualify for FMLA leave which means your medical-dental insurance may be paid for you and the leave will be counted as part of the 12 weeks of FMLA leave you are eligible to take. **YOU ARE REQUIRED TO EXHAUST ALL ACCRUED PAID LEAVE (EXCEPT 40 HOURS OF VACATION) IN ACCORDANCE WITH THE COLLECTIVE BARGAINING AGREEMENTS PRIOR TO BEING PLACED ON LEAVE WITHOUT PAY DURING FMLA/OFLA**

Signature of Employee

Date

Signature of Supervisor*

Date

***Supervisor:** If FMLA/OFLA leave is requested (#2, 3, 4 or 6), you must send this form to Human Resources for approval and federal recordkeeping requirements.

If reason #5 is checked, please contact Human Resources to verify employee's eligibility for OFLA protections. When reason #5 applies, these records are retained within the department, and hours are tracked within the department. Human Resources *will not* need a copy of this form when #5 is the applicable reason for the leave.

Eligibility Rules

Family Medical & Leave Act (FMLA)

Maximum Leave: 12 weeks in a 12-month period (12 consecutive weeks for foster care, adoption, or care for a newborn child unless intermittent or reduced hours leave is approved by the supervisor).

Eligibility: You must have at least 12 months of employment with the State of Oregon (need not be consecutive service time); **AND**, during your last 12 months of employment prior to the date leave commences, you must have worked at least 1250 hours.

A "Serious Health Condition" means an illness, injury, impairment, or physical or mental condition that involves one of the following: (Conditions that do not meet definition unless complications arise are: common cold, flu, ear aches, upset stomachs, minor ulcers, and headaches other than migraines).

1. Hospital Care

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

2. Absence Plus Treatment

(a) 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:

(1) Treatment 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

(2) Treatment by a health care provider on at least one occasion which results in a regimen of continuing treatment 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

(1) 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;

(2) Continues over an extended period of time (including recurring episodes of a single underlying condition); and

(3) 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 (Non-Chronic 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).

Oregon Family Leave Act (OFLA)

Maximum Leave: 12 weeks in a 12-month period (some exceptions apply)

Eligibility: For OFLA leaves due to serious health conditions or pregnancy, you must have at least 180 calendar days of consecutive UO employment and have worked an average of 25 or more hours per week during the prior 180 days. There is no hours test for OFLA leaves to care for a newborn child or for adoption.

If eligible only for OFLA, the definition of a serious health condition closely tracks the FMLA serious health condition definitions listed above. OFLA also includes a terminal illness or imminent danger of death and constant or continuing care.

If leave qualifies under both the FMLA and OFLA, or the FMLA and contractual benefit provisions, its use is counted against both entitlements. Any FMLA leave will also count as OFLA leave.