Employee Leave Checklist
Family Member Serious Health Condition, Sick Child Leave, or Serious Health Condition Current Military or Veteran

You may be eligible for leave under the Family Medical Leave Act (FMLA) and/or the Oregon Family Leave Act (OFLA). These leaves entitle eligible employees up to 12 weeks of FMLA/OFLA leave in a 12 month period. FMLA/OFLA protect your job and benefits. This leave is not a paid leave unless you have sick and/or vacation time to use.

STEP 1: INFORMATION TO READ AND REVIEW

- FMLA Employee Rights Notice
- OFLA Employee Rights Notice
- OIT Notice of Employee Rights

STEP 2: %s€ÐÀ 0

- FMLA/OFLA Leave Request Form – complete and return to HR

STEP 3: MEDICAL CERTIFICATION

- Medical Certification – give to Medical provider and have them return to HR

STEP 4: LEAVE AND LEAVE BENEFITS

- Complete your FMLA/OFLA Attendance Record/Leave Tracking Form and your Employee Leave slip every month

STEP 5: RETURN TO WORK

Family Member Serious Health CondiŸ

EMPLOYEE RIGH

UNDER ~~THE FAMILY AND MEDICAL LEA~~

BUREAU OF LABOR AND INDUSTRIES

Oregon

FAMILY LEAVE ACT

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Notice of Employee Rights and0 14.04 e4te5 (t)7.1 (s)
against your leave entitlement. Generally you are entitle

- Public Universities/SEIU Collective Bargaining Agreem
- Unclassified Employees (faculty and administrative staff)
  unclassified employees may use accrued vacation and
  unpaid status (leave without pay).
- Employees may not go in and out of unpaid status, u

Leave of Absence Request Form

EMPLOYEE INFORMATION
Name:

Personal Email:	
Mailing Address:	
Phone:	

Contact information while on leave

HEALTH CARE PROVIDER
CERTIFICATION FOR SERIOUS HEALTH CONDITION

This optional form is designed to help determine if an employee is eligible for leave under either or both the federal Family and Medical Leave Act (FMLA) and/or the Oregon Family Leave Act (OFLA) .

▲ Indicates that an affirmative answer to this question is not required for OFLA or concurrent OFLA & FMLA leave.

* Indicates categories that qualify as OFLA leave only.

Employer s are not required to use this form in order to designate leave as OFLA or FMLA protected.

Information sought on this form relates only to the condition for which the employee is taking leave.

SECTION I: For Completion by the EMPLOYER

INSTRUCTIONS to the EMPLOYER: The Family and Medical Leave Act (FMLA) and the Oregon Family Leave Act (OFLA) provide /OFLA protections because of a need for leave to care for a covered family member with a serious health condition or because of a need for leave due to H P S O R \ H H ¶ V R Z Q serious health condition to submit a medical certification issued by the health care provider of the covered family member or D P H G L F D O F H U W L I L F D W L R Q L V V X H G E \ W K H own health care provider, whichever is appropriate. Please complete Section I before giving this form to your employee. Your response is voluntary. While you are not required to use this form, you may not ask the employee to provide more information than allowed under the FMLA regulations, 29 C.F.R. §§ 825.306-825.308. Employers must generally maintain records an

SECTION II: For Completion by the EMPLOYEE

INSTRUCTIONS to the EMPLOYEE: Please complete Section II before giving this form to your employer.

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SECTION III : For Completion by the HEALTH CARE PROVIDER

INSTRUCTIONS to the HEALTH CARE PROVIDER: Either your patient has requested leave under the FMLA/OFLA or the employee listed above has requested leave under the FMLA/OFLA to care for your patient.

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Is this care medically necessary? No ☐ Yes ☐

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

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

_____

_____

Is this care medically necessary? No ☐ Yes ☐

7) Will it be necessary for the employee to take leave only intermittently or to work on a less than full time schedule basis because of the condition or treatment? No ☐ Yes ☐

If "Yes", expected duration: _____

Frequency (Check One):

☐ One (1) to two

CONTINUED ON NEXT PAGE

9) Will the condition cause episodic flare-ups periodically preventing the patient from participating in normal daily activities or performing his/her job functions? No-☐ Yes-☐

If "yes", is it medically necessary for employee to be absent from work during the flare-ups?

No-☐ Yes-☐ If "yes", please explain: _____

Affirmative answer not required for OFLA or concurrent leave

_____

FMLA/OFLA ATTENDANCE RECORD / LEAVE TRACKING FORM

Name:
Department:
Employee ID#:
Instructions:

Month	Year	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31	Total
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Employee's Signatur

Supervisor's Signature:
Date:

For additional information or to le a complaint:

1-866-4-USWAGE

(1-866-487-9243) TTY: 1-877-889-5627

www.dol.gov/whd

U.S. Department of Labor | Wage and Hour Division