

OREGON DEPT OF TRANSPORTATION – FAMILY AND MEDICAL LEAVE FORM

Federal and Oregon Family and Medical Leave Acts

This form is to be completed and given to your manager for review and approval prior to submitting to your Human Resources representative.

Name: _____ AEE SEIU Mgmt Svc/ Exec/ Unrep'd

Division/Section: _____ Crew # _____

I will need a **continuous block** of leave from: _____ to: _____

I will need **intermittent/irregular** leave from: _____ to: _____

The reasons for leave listed below are covered under federal and/or state Family and Medical Leave laws. Approval of medical leave is subject to certification by a health care provider. Check appropriate box or boxes.

Your own serious health condition.

Care for a family member's serious health condition:

Check one only: spouse, parent, or biological, adopted, or foster daughter or son.

a. What type care will you provide? _____

b. At what times (on what schedule) will you provide this care? _____

c. Is(are) there any other family member(s) taking leave, or are otherwise available, during this same period to provide care? If yes, give your reason for requesting leave in addition to theirs: _____

Care for a family member who is in the military and injured while on active duty (FMLA only, up to 26 weeks).

Pregnancy disability (including prenatal care appointments). ***Anticipated date of birth:** _____

Parental leave (newborn*, newly adopted**, or newly placed foster** daughter or son), available to both male and female employees. (Length of leave is up to 12-weeks within first 12-months of birth or placement.)

**Give date of adoption or foster placement: _____ Is/are child/ren under 18 yrs old? Yes No

OFLA ONLY:

Care for parent-in-law, same-sex domestic partner, grandparent or grandchild with condition that poses imminent danger of death, is terminal or requires constant care:

a. What type of care will you provide? _____

b. At what times (on what schedule) will you provide this care? _____

At-home care for a minor child suffering from an illness or injury that is a non-serious health condition.

Is the child's other parent, or other family relative, available and able to care for the child? Yes No

Employees using FMLA/OFLA entitlements shall first exhaust sick leave in accordance with union contracts or established DAS policy. Please number below the order in which you choose to use paid leaves after exhausting sick leave:

AEE employees are not required to use other paid leaves before incurring leave without pay.

___ **VA** – vacation ___ **CT** – Comp-Time⁽¹⁾ ___ **LO** – Leave Without Pay

SEIU represented, employees are required to exhaust all paid leaves⁽²⁾ before using leave without pay.

___ **VA** – vacation ___ **PB** – personal business ___ **CT** – Comp-Time⁽¹⁾

⁽²⁾ I am taking a continuous block of leave and designate to retain up to 40 hours of vacation/comp-time. (I understand that if I retain vacation/comp-time hours, I will not be eligible for Hardship Leave Donations.)

Mgmt Service/ Exec/ Unrepresented employees are required to exhaust all paid leaves before using leave without pay.

___ **VA** – vacation ___ **PB** – personal business ___ **CT** – Comp-Time⁽¹⁾

(1) You do not have to use your compensatory time unless you want to.

I understand that I am required to provide medical certification and that failure to provide adequate certification may delay or disqualify my entitlement to the federal Family and Medical Leave Act and/or the Oregon Family Leave Act entitlements. I certify that all statements contained in this request are true and complete. Any oral or written statements that are false and/or misleading may be grounds for disciplinary action.

Employee Signature

Employee ID Number

Date Signed

Supervisor Signature

Please Print Name

Date Signed

**Oregon Department of Transportation
Family and Medical Leave
RELEASE TO RETURN TO WORK**

A. PRIOR TO EMPLOYEE RETURNING TO WORK, this form is to be faxed to ODOT Human Resources (see bottom of page for fax information) and a COPY is to be SUBMITTED to the EMPLOYEE'S SUPERVISOR.

B. TO BE COMPLETED BY EMPLOYEE:

Name: _____ EIN: _____

C. TO BE COMPLETED BY ATTENDING PRIMARY HEALTH CARE PROVIDER:

1. The above named employee was examined on (date): _____

2. Is the employee able to return to work full-time without restrictions? * Yes No

*Effective Date: _____

3. If the answer to #2 is "No", indicate date employee **is able** to return to work full-time with **NO** limitations: _____

Additional Comments: _____

4. Period of absence: I certify that from _____ to _____ the above named employee was: (a) unable to perform the physical requirements of his/her work **and/or** (b) medically incapacitated: Totally **Partially

5. **If *partially medically incapacitated*, complete the following:

Number of hours per day employee is able to work _____

Number of days per week employee is able to work _____

6. Limitation(s): Bending Sitting Lifting Standing Walking Other

Please explain/describe limitations in detail: _____

PRINTED Name of Primary Health Care Provider

Type of Practice

Signature – Primary Health Care Provider

Date

**Please send completed form to your HR Analyst at:
FAX to: 503-378-3481**

**ATTN: OFLA/FMLA HR Specialist
ODOT Human Resources
3930 Fairview Industrial Dr. SE MS#4
Salem, OR 97302**