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| ***Click here to enter a date*** |
| ***Click here to enter First and Last Name*** |
| ***Click here to enter Street Address*** |
| ***Click here to enter Agency City, State Zip*** |
| **Subject: Family & Medical Leave Agency Designation and Exhaust Notice – Paid Leave Oregon** |
| We have been notified of the potential need for you to take leave under the Federal Family and Medical Leave (FMLA) and Oregon Family Leave (OFLA) acts. Based on the information we received on ***Click here to enter a date***, it has been decided: |
| **Protected Leave Designation:** |
| **FMLA** | Leave for ***Click here to enter Qualifying Event*** ***Click here to enter Approval*** Your FMLA leave year will run ***Click here to enter a date*** through ***Click here to enter a date***. |
| Additional Comments:  |
| Condition Identifier: |
| **OFLA** | Leave for ***Click here to enter Qualifying Event*** ***Click here to enter Approval*** Your OFLA leave year will run ***Click here to enter a date*** through ***Click here to enter a date***. |
| Additional Comments:  |
| Condition Identifier: |
| **Paid Leave Oregon** | Because you were approved for Paid Leave Oregon by the Oregon Employment Department for your qualifying condition, you are entitled to an additional four (4) weeks of unpaid protected leave under Paid Leave Oregon, for any OFLA qualifying condition to be used during your benefit year. Your Paid Leave Oregon benefit year will run ***Click here to enter a date*** through ***Click here to enter a date***. |
| Additional Comments:  |
| Condition Identifier: |

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| **Dates Scheduled for Leave:** |
| Block of time from ***Click here to enter a date*** through ***Click here to enter a date*** |
| Additional Comments:  |
| Intermittently from ***Click here to enter a date*** through ***Click here to enter a date***  |
| Additional Comments: *Because your leave will be unscheduled it is not possible to provide the hours, days, or weeks that will be counted against your leave entitlement at this time. You may ask for an update on leave available to you no more than every 30 days during the months in which you are taking Family and Medical Leave.* |
| Reduced schedule from ***Click here to enter a date*** through ***Click here to enter a date*** |
| Additional Comments:  |

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| **Leave Available:** |
| The current leave available to you for this leave year as of ***Click here to enter a date*** are: |
| **FMLA** | ***Click here to enter FMLA Hours*** |
| **OFLA** | ***Click here to enter OFLA Hours*** from ***Click here to enter a date*** through ***Click here to enter a date***And ***Click here to enter OFLA Hours*** from ***Click here to enter a date*** through ***Click here to enter a date*** |
| You are projected to exhaust these hours on or about: ***Click here to enter a date*** |

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| **Workday Processing:** |
| All time related to your leave must be entered in Workday with the following approved leave type: |
| ***Click here to enter Qualifying Event*** |
| Please ensure all protected leave is requested in Workday |
| **You are required to make two separate Workday entries:*** One request for your protected leave (FMLA, OFLA, Paid Leave, etc.) – routed to your absence partner for approval.

**And** one for your accrued leave or Leave Without Pay – routed to your manager for approval. |

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| **Block of Time:** If your leave is expected to go beyond the projected exhaust date, it will require agency pre-approval. Per ***Click here to enter Bargaining Unit Language***. If you are requesting LWOP for an extended period, you must submit a written request to ***Click here to enter Contact Information*** within ***Click here to enter Number of Days*** days. A supporting statement from your healthcare provider ***Click here to enter Is or Is Not*** needed to certify the continued need for leave and must include and anticipated return to work date.**Release to Return to Work:** Prior to returning to work, a statement from your healthcare provider certifying you are released to return to work full-time with or without restrictions ***Click here to enter Is or Is Not*** required. If your healthcare provider indicates work restrictions on the release form, these will be reviewed to determine if there is suitable and available work. The form, if required, is included with this letter. **Return to Work:** You must contact your supervisor with and update to your plans to return to work on or before ***Click here to enter a date***.**Intermittent Absence from Work:** Any absence from work after exhausting your Family and Medical Leave entitlements including the use of leave without pay (LWOP), will require agency approval. Any absence for which the agency has not approved may be charged to unauthorized leave without LWOP.**Insurance Benefits:** Under Public Employees Benefits Board (PEBB) guidelines, in order for your insurance benefits to continue without interruption, you will be required to have 80 hours of paid status (e.g., work or paid leave) within a calendar month in order for the agency to continue to pay all or part of your insurance premium payments. If you do not have accrued leave available to cover your absence, you will need to contact Payroll at ***Click here to enter Payroll’s Contact Information*** regarding continuing your benefits through Affordable Care Act (ACA) or COBRA.**Workers Compensation:** If you are off work due to a Workers Compensation claim, your benefits will continue to be paid by the agency in accordance with Covered Benefits for Injured Workers (CBIW) regulations. There will be no gap in coverage. |
| Please contact us if you have any questions concerning your Family and Medical Leave entitlements. |

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| **Signature:** | ***Click here to enter your name/signature*** |
| **Position:** | ***Click here to enter Your Position or Title Name*** |
| **Phone:** | ***Click here to enter Phone Number(s)*** |
| **Fax:** | ***Click here to enter Fax Number*** |