MEDICAL LEAVE – CARE OF FAMILY MEMBER CHECKLIST

Do **NOT** give the entire leave packet to your health care provider. **Separate** the forms at the end of the leave packet to use at the appropriate time. **Submit** all forms directly to the Leave Coordinator.

_____ 1) **Read the Detailed Leave Instructions** – on the following pages

_____ 2) ***Employee Request for Family, Medical, or Military Leave Form***
Due: At least 30 days in advance or immediately
Do NOT wait to submit your request until you have medical certification
Obtain Supervisor/Administrator signature and forward to hr_leave@ddouglas.k12.or.us

_____ 3) Medical Certification - ***Form WH-380-F***
Planned absence: This is due before starting your leave
Unplanned absences: This is due within 15 calendar days of first missing work
Scan/email or fax this directly to the hr_leaves@ddouglas.k12.or.us

_____ 4) Change to health insurance - ***Midyear Change Form***
Due: within 31 days of change.
If you are needing to add/drop a dependent to your health insurance, please complete Midyear Change Form and submit to the Benefits Coordinator.
You may download form at: https://www.ddouglas.k12.or.us/departments/human-resources/current-employee-information/hr-employee-documents-and-forms/

_____ 5) Report your absences
If continuous, report your absences & paid leave to hr_leave@ddouglas.k12.or.us
If intermittent, obtain a Leave # from the Leave Coordinator and enter your absences into the appropriate timekeeping system (Timecard, TimeClock+, or Absence Mgmt.)
You may use any available accrued paid leave
Check iVisions or TimeClock+ for your paid leave balances
https://ivweb.nwtoolbox.org/daviddouglas/Home/tabid/36/Default.aspx

Resources:

Leave Coordinator
Phone: 503-261-8416
Confidential Fax: 503-261-0130
HR_Leave@ddouglas.k12.or.us

MEDICAL LEAVE INSTRUCTIONS – CARE OF FAMILY MEMBER

Submit all documents to Leave Coordinator
Confidential Fax: 503-261-0130 | Phone: 503-261-8416 | Email: hr_leaves@ddouglas.k12.or.us

DOCUMENTS: The Medical Leave Packet contains the necessary forms. Send all documents to the Leave Coordinator.
REQUEST LEAVE: Complete the *Employee Request for Family, Medical, or Military Leave* form as soon as your need for leave is known, with 30 days prior notice when possible. Once you request leave, the Leave Coordinator will issue you a Leave Number.
MEDICAL CERTIFICATION (WH-380-F): You will need to complete the first Section II of the form and then have the health care provider complete Section III. Send the medical certification directly to the Leave Coordinator for medical confidentiality. This is due prior to your leave beginning or within 15 calendar days that your need for leave becomes known. If there are extenuating circumstances that will not allow you to meet this deadline, please communicate with the Leave Coordinator. Failure to provide a complete and sufficient medical certification in a timely manner may result in a denial of your FMLA and/or OFLA request, and may be subject to applicable District policies.
REPORTING YOUR ABSENCES: You are required to follow normal absence reporting procedures. ***If your absence will be 3 days or less***, you are responsible for notifying your supervisor as well as completing your Timecard, entering time into TimeClock+, and/or Absence Management (formerly Aesop) – whatever is applicable. Your Timecard, TimeClock+, and/or Absence Management should include the paid leave code you want to use as well as the Leave # associated with this leave. ***If your absence is 4 days or more***, you are responsible for reporting your absences with how you would like to use your accrued paid leaves to the Leave Coordinator. To check your available paid leave balances, please log onto iVisions.
REQUESTING LEAVE EXTENSIONS: If you wish to extend your leave, please submit an email request to both your Administrator/Supervisor and the Leave Coordinator at least 30 days prior to the end of your approved leave. Unpaid Leave: A request to take additional unpaid leave, beyond your FMLA and/or OFLA entitlement, may fall under the Collective Bargaining Agreement. The Leave Coordinator will be in contact with you if your leave extension request fits into any of these categories.
CHANGE TO HEALTH INSURANCE: If you are needing to add or drop a dependent due to a change in family status (birth or a child, death of family member), please complete the Midyear Change Form and submit it to our Benefits Coordinator. This must be done within 31 days of the change.
INTERMITTENT LEAVE: In addition to your normal absence reporting procedures: Scheduled absences: You must advise your Administrator/Supervisor that it is part of your FMLA/OFLA leave and provide your Administrator/Supervisor with as much notice as possible. It is expected that you will schedule, to the best of your ability, leave-related appointments during your time off. Unexpected absences: You must also inform your Administrator/Supervisor at the time of your absence, or within 24 hours of your return that the absences was part of your FMLA/OFLA intermittent leave. Failure to do this will cause the absence to not maintain protected status. Follow normal absence reporting procedures. You must report your absence in your appropriate timekeeping system **and** include your issued Leave Number for each absence, **and** report what type of paid leave you want to use. Intermittent leave is to be used for qualifying medical related reasons, in accordance with the medical certification. Changes to your leave: If the frequency and duration of your need to care for yourself or an eligible family member changes, you will need to provide updated medical certification stating the medical reason for the change.
RETURN TO WORK: Please contact your Administrator/Supervisor and the Leave Coordinator by phone or email the week prior to your return to confirm your return.
USE OF PAID LEAVE: The District allows you to use any paid leaves you have available at the onset of your leave with one exception. In the case that you begin your contract year out on leave, you may not access your Family Illness, Emergency, Bereavement, or Personal Business leave until you have worked at least two weeks in the new contract year.
BENEFITS WHILE ON LEAVE: Your District-paid benefits via the fringe cap will continue if you on a paid status (i.e Sick Leave) or on an approved FMLA/OFLA leave. However, you are still responsible for any out-of-pocket premiums not covered by the fringe cap provided by the District.
OTHER: Licensed employees are required to maintain licensure under TSPC while on leave. Failure to maintain an active TSPC license during your leave may impact your ability to return to work.

EMPLOYEE REQUEST FOR FAMILY, MEDICAL, OR MILITARY LEAVE

Fax: **503-261-0130** or email: hr_leave@ddouglas.k12.or.us

Part 1: EMPLOYEE INSTRUCTIONS

This request is required for family or medical absences of 4 days or more

Bring or fax the form immediately to Leave Coordinator, 503-261-0130.

1. If the reason for leave is foreseen, your request is due as soon as you become aware, preferably 30 days prior to your leave. If your leave was unforeseeable, you must give the District oral notice as soon as practicable and provide the Leave Coordinator with this completed form within 3 days of returning to work.
2. Provide supporting medical certification/documentation to the Leave Coordinator within 15 calendar days of your request, or before your leave begins.

A. PERSONAL INFORMATION ☐ CLASS ☐ LICN ☐ ADMIN/SUPER/CONFID

Name _____ Building _____

Preferred Email _____ Preferred Phone _____

Job Title _____ Address _____

B. REASON(S) FOR LEAVE

☐ **Employee's Own Illness** – serious health condition

☐ **Bonding** – leave for ___ birth, ___ adoption, or ____ foster care.
Anticipated date of birth or placement: _____

- ☐ I would like to take the full 12 weeks of bonding leave allowed
- ☐ My request is less than 12 weeks. I understand that extensions require at least 30 days' notice and that once I return I forfeit additional bonding leave

☐ **Family Medical Care** – serious health condition ☐ **Injured Service Family Member** (FMLA only)
Name of family member _____ Relationship to employee _____

☐ **Qualifying Military Exigency** – Military Family Member (FMLA/OFLA)
Name of family member _____ Relationship to employee _____

☐ **Military Service (USERRA)** – Supply copy of official orders to Leave Coordinator

☐ **Bereavement (OFLA only)**
Name of family member _____ Relationship to employee _____

C. ABSENCE REQUEST (Check all that apply – estimated dates must be entered)

☐ **CONTINUOUS** From _____ To _____ Return _____

☐ **REDUCED SCHEDULE** From _____ To _____ Return _____
Describe requested schedule (i.e. 4 hours per day for 3 weeks) _____

☐ **INTERMITTENT** (not for bonding leave) From _____ To _____
Intermittent leave: complete the following in full – do not leave blank or answer "unknown." Use additional paper if necessary.

- ☐ Medical treatment for myself or an eligible family member
- ☐ Episodes of chronic illness that result in ___my inability to work or _____my family member's inability to perform activities of daily living

How often will these absences occur _____

When they do occur how much time will you need _____

D. COMMENTS ABOUT LEAVE REQUEST

E. EMPLOYEE SIGNATURE – Read the following rights and responsibilities carefully before signing

- I understand that I may use my paid leave prior to taking unpaid leave. I understand that my fringe cap the District provides me only protects my benefits during the time in which my leave is protected under FMLA/OFLA and/or when I exhaust my paid leave.

- I understand that I am required to provide supporting documentation, medical or otherwise to the Leave Coordinator within 15 calendar days of this request or before my leave begins, whichever is later. Failure to provide a complete and sufficient medical certification in a timely manner may result in a denial of you FMLA and/or OFLA request, may be subject to applicable District policies.

- I understand that I am responsible for ensuring my absences are reported according to my department and District policy. **If my absences are intermittent or 3 consecutive days or less,** I will report them to the Leave Coordinator at hr_leave@ddouglas.k12.or.us, and enter my absence into my appropriate timekeeping system. **If my absences are 4 days or more,** I report my absences and how I want to use my paid leaves to hr_leave@ddouglas.k12.or.us. I will check with my Administrator/Supervisor if I am uncertain or my responsibilities or need assistance reporting my absences while on leave.

- I understand that if I do not return to work following my FMLA/OFLA leave I may no longer receive protections under these laws, which may affect my group health insurance and possibly my employment.

EMPLOYEE SIGNATURE _____ DATE _____

DR.

Certification of Health Care Provider for Family Member's Serious Health Condition (Family and Medical Leave Act)

U.S. Department of Labor
Wage and Hour Division

U.S. Wage and Hour Division

DO NOT SEND COMPLETED FORM TO THE DEPARTMENT OF LABOR; RETURN TO THE PATIENT.

OMB Control Number: 1235-0003
Expires: 5/31/2018

SECTION I: For Completion by the EMPLOYER

INSTRUCTIONS to the EMPLOYER: The Family and Medical Leave Act (FMLA) provides that an employer may require an employee seeking FMLA protections because of a need for leave to care for a covered family member with a serious health condition to submit a medical certification issued by the health care provider of the covered family member. 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 and documents relating to medical certifications, recertifications, or medical histories of employees' family members, created for FMLA purposes as confidential medical records in separate files/records from the usual personnel files and in accordance with 29 C.F.R. § 1630.14(c)(1), if the Americans with Disabilities Act applies, and in accordance with 29 C.F.R. § 1635.9, if the Genetic Information Nondiscrimination Act applies.

Employer name and contact: David Douglas School District - Human Resources

SECTION II: For Completion by the EMPLOYEE

INSTRUCTIONS to the EMPLOYEE: Please complete Section II before giving this form to your family member or his/her medical provider. The FMLA permits an employer to require that you submit a timely, complete, and sufficient medical certification to support a request for FMLA leave to care for a covered family member with a serious health condition. If requested by your employer, your response is required to obtain or retain the benefit of FMLA protections. 29 U.S.C. §§ 2613, 2614(c)(3). Failure to provide a complete and sufficient medical certification may result in a denial of your FMLA request. 29 C.F.R. § 825.313. Your employer must give you at least 15 calendar days to return this form to your employer. 29 C.F.R. § 825.305.

Your name: _____
First Middle Last

Name of family member for whom you will provide care: _____
First Middle Last

Relationship of family member to you: _____

If family member is your son or daughter, date of birth: _____

Describe care you will provide to your family member and estimate leave needed to provide care:

_____

_____

_____

_____ _____
Employee Signature Date

CONTINUED ON NEXT PAGE

SECTION III: For Completion by the HEALTH CARE PROVIDER

INSTRUCTIONS to the HEALTH CARE PROVIDER: The employee listed above has requested leave under the FMLA to care for your patient. Answer, fully and completely, all applicable parts below. Several questions seek a response as to the frequency or duration of a condition, treatment, etc. Your answer should be your best estimate based upon your medical knowledge, experience, and examination of the patient. Be as specific as you can; terms such as "lifetime," "unknown," or "indeterminate" may not be sufficient to determine FMLA coverage. Limit your responses to the condition for which the patient needs leave. Do not provide information about genetic tests, as defined in 29 C.F.R. § 1635.3(f), or genetic services, as defined in 29 C.F.R. § 1635.3(e). Page 3 provides space for additional information, should you need it. Please be sure to sign the form on the last page.

Provider's name and business address: _____

Type of practice / Medical specialty: _____

Telephone: (___) _____ Fax: (___) _____

PART A: MEDICAL FACTS

1. Approximate date condition commenced: _____

   Probable duration of condition: _____

   Was the patient admitted for an overnight stay in a hospital, hospice, or residential medical care facility?
   ___No ___Yes. If so, dates of admission: _____

   Date(s) you treated the patient for condition: _____

   Was medication, other than over-the-counter medication, prescribed? ___No ___Yes.

   Will the patient need to have treatment visits at least twice per year due to the condition? ___No ____ Yes

   Was the patient referred to other health care provider(s) for evaluation or treatment (e.g., physical therapist)?
   ____ No ____Yes. If so, state the nature of such treatments and expected duration of treatment:

   _____

   _____

2. Is the medical condition pregnancy? ___No ___Yes. If so, expected delivery date: _____

3. Describe other relevant medical facts, if any, related to the condition for which the patient needs care (such medical facts may include symptoms, diagnosis, or any regimen of continuing treatment such as the use of specialized equipment):

_____

_____

_____

_____

PART B: AMOUNT OF CARE NEEDED: When answering these questions, keep in mind that your patient's need for care by the employee seeking leave may include assistance with basic medical, hygienic, nutritional, safety or transportation needs, or the provision of physical or psychological care:

4. Will the patient be incapacitated for a single continuous period of time, including any time for treatment and recovery? ___No ___Yes.

   Estimate the beginning and ending dates for the period of incapacity: _____

   During this time, will the patient need care? __ No __ Yes.

   Explain the care needed by the patient and why such care is medically necessary:

   _____

   _____

   _____

   _____

   _____

5. 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:

   _____

   Explain the care needed by the patient, and why such care is medically necessary: _____

   _____

6. Will the patient require care on an intermittent or reduced schedule basis, including any time for recovery? __ No __ Yes.

   Estimate the hours the patient needs care on an intermittent basis, if any:

   _____ hour(s) per day; _____ days per week from _____ through _____

   Explain the care needed by the patient, and why such care is medically necessary:

   _____

   _____

   _____

   _____

7. Will the condition cause episodic flare-ups periodically preventing the patient from participating in normal daily activities? ____No ____Yes.

   Based upon the patient's medical history and your knowledge of the medical condition, estimate the frequency of flare-ups and the duration of related incapacity that the patient may have over the next 6 months (e.g., 1 episode every 3 months lasting 1-2 days):

   Frequency: _____ times per _____ week(s) _____ month(s)

   Duration: _____ hours or ___ day(s) per episode

   Does the patient need care during these flare-ups? ____ No ____ Yes.

   Explain the care needed by the patient, and why such care is medically necessary: _____

_____

_____

_____

_____

ADDITIONAL INFORMATION: IDENTIFY QUESTION NUMBER WITH YOUR ADDITIONAL ANSWER.

_____

_____

_____

_____

_____

_____

_____ _____

Signature of Health Care Provider **Date**

PAPERWORK REDUCTION ACT NOTICE AND PUBLIC BURDEN STATEMENT

If submitted, it is mandatory for employers to retain a copy of this disclosure in their records for three years. 29 U.S.C. § 2616; 29 C.F.R. § 825.500. Persons are not required to respond to this collection of information unless it displays a currently valid OMB control number. The Department of Labor estimates that it will take an average of 20 minutes for respondents to complete this collection of information, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. If you have any comments regarding this burden estimate or any other aspect of this collection information, including suggestions for reducing this burden, send them to the Administrator, Wage and Hour Division, U.S. Department of Labor, Room S-3502, 200 Constitution Ave., NW, Washington, DC 20210.
DO NOT SEND COMPLETED FORM TO THE DEPARTMENT OF LABOR; RETURN TO THE PATIENT.

Human Resources Contacts

Candy Wallace
Assistant Superintendent 503-261-8205

Darcy Powers
Human Resources Manager 503-261-8226
Job Postings – Licensed and Administrative, All Licensed Staff Questions, TeachPoint – Licensed Staff Evaluation System

Stefanie Edenburn
Human Resources Benefits Coordinator 503-261-8250
Health Benefits, Insurance, Retirees, Job Postings – Classified and Administrative, All Classified Staff Questions

Gloria Cruz
Human Resources Leave Coordinator 503-261-8416
Worker's Compensation, Licensed Non-Medical Leaves of Absence, FMLA/OFLA, Classified Leaves of Absence

Leah Hadley
Human Resources Administrative Assistant - Classified..... 503-261-8253
Applications, Classified New Hire Orientations, Personnel Action Forms, Para-Professional Examinations, Volunteer Applications, Classified Tuition Reimbursement, Job Postings – Classified

Debora Speciale
Human Resources Administrative Assistant - Licensed 503-261-8225
Licensed New Hire Orientations, Unemployment Insurance, Student/Practicum Teacher Placements, Licensed Tuition Reimbursement, Job Postings – Licensed

Tiara Carter
Human Resources Assistant 503-261-8289
Human Resources Help Desk, Security Badges, Volunteer forms, Background checks

David Petersen
Human Resources Technology/Data & Security Coordinator 503-261-8210
SafeSchools Employee Training, HR Newsletter, HR Webpage, TeachPoint – Licensed Staff Evaluation System, Building Alarms and Keys, Security Badges