Oregon Department of Corrections

Family Medical Leave Act (FMLA) and Oregon Family Leave Act (OFLA) Forms Packet

Please read this statement before proceeding

This packet is a summary of Family and Medical Leave policy and procedures. In all cases applicable state and federal laws, rules, policies and collective bargaining agreements govern the employee's and the agency's rights and obligations; not this document.

FMLA and OFLA are not optional. The law requires the agency to provide these entitlements.

Federal and state law prohibit retaliation against an employee with respect to hiring or any other term or condition of employment because the employee asked about, requested or used Family and Medical Leave.

Why am I receiving this packet?

- It was requested by you, or
- We were notified that you had an absence of more than three consecutive calendar days that may qualify under FMLA and/or OFLA

What do I need to do next?

- Have the medical provider complete the applicable form. There is an Employee Health Care Provider Certification form and a Family Member Health Care Provider Certification form attached.
- If you were incapacitated for more than seven days (for your own absence), have your medical provider complete the attached Employee Medical Status Report (EMSR) form and return to your supervisor.
- If you did not seek medical attention for your absence, please contact your FMLA/OFLA Analyst (listed below) immediately.
- Complete and submit a leave request within 3 days of your return to work.

Fax Completed Forms to (503) 362-2078

Margo Hammonds (503) 934-1013
Margo.Hammonds@doc.state.or.us
Mon-Thurs 7:00-4:30p.m.; Fri 7:00-11:00a.m.

SRCI, SCCI, CRCI/SFFC, WCCF

Christine Welter (503) 934-1036
Christine.Welter@doc.state.or.us
Tues-Weds 7:00-4:00p.m.; Fri 7:00-11:00a.m.

CCCF, HS Admin, CDC, CTRS, Parole Board Dome

Serena Thompson (503) 934-1083
Serena.Thompson@doc.state.or.us
Mon, Tues, Thu 8:30-1:30p.m.; Fri 10:00-3:00p.m.

MCCF, OSP, PRCF, Douglas, Linn

Angela Allen (503) 934-1057
Angela.J.Allen@doc.state.or.us
Tues-Fri 7:00-5:30p.m.

DRCI, EOCI, OSCI, SCI, TRCI

HEALTH CARE PROVIDER CERTIFICATION
For Employee's Serious Health Condition
Family and Medical Leave (PD 615A)

Oregon Department of Corrections

This form is used to provide certification per FMLA and OFLA regulations and law.

Section I: Employee Completes this Section

Employee's name: _____ **Work Location:** _____

Personal E-mail (optional): _____ **Contact Number (optional):** _____

Section II: Health Care Provider Completes this Section

Please complete all sections in order for the agency to determine Family and Medical leave entitlement.

1. Please mark all that pertain to this patient (descriptions are on Page 2 of this certification):

- A. ☐ Requires hospital care (hospice, residential care facility)
- B. ☐ Requires absence from work plus treatment
- C. ☐ Pregnancy disability or requires prenatal care
- D. ☐ Chronic condition requiring treatment
- E. ☐ Permanent or long-term condition requiring supervision
- F. ☐ Requires multiple treatments for a non-chronic condition
- G. ☐ None of the above

Describe the medical facts that support the above (such medical facts may include symptoms, diagnosis, surgery or any regimen of treatment). _____

_____

_____

2. Approximate date this condition began _____

3. **Estimate the employee's current dates of incapacity/absence from work** _____

4. Is this for either a chronic condition or for pregnancy? ☐ yes ☐ no If yes, is the patient presently incapacitated? ☐ ☐ yes ☐ no If yes, what is the expected duration of the incapacity? _____
What is the expected frequency of the incapacity? _____

5. Will it be necessary for the employee to take time off intermittently or work on a reduced schedule due to the patient's condition or treatment? ☐ yes ☐ no If yes, what is the expected frequency for the absence?
☐ _____days per week, ☐ _____ days per month, ☐ reduce hours worked in a day to _____ for _____ days per week, ☐ other (describe): _____

6. Did the patient require treatment (prescription, follow-up appointment, etc.)? Will the patient require a regimen of treatments? ☐ yes ☐ no If yes to either, describe the nature of the treatments, number of treatments needed and the intervals between treatments _____

_____

7. If the patient is not the employee, please use the Family Member Health Care Provider Certification form.

_____ _____ _____

Signature of Health Care Provider | Printed Name of Health Care Provider | Date Signed

Field of Practice: _____ Health Care Provider Address: _____

Return form to the patient or FAX to the Oregon Dept. of Corrections, FMLA/OFLA at (503) 362-2078.

DEFINITIONS

This page defines the various serious health condition categories listed in section 1, A-G on the front of this certification. **A "serious health condition" is defined as an illness, impairment, physical or mental condition that involves one or more of the following:**

A. Hospital care: Inpatient care (i.e. overnight stay) in a hospital, hospice, or residential medical care facility, including any period of incapacity or subsequent treatment in connection with or as a consequence of such inpatient care.

B. Absence plus treatment: 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 one or both of the following:

a. Treatment received in person, two or more times by a health care provider, a nurse, or a physician's assistant under direct supervision of a health care provider, or a provider of health care services (e.g., physical therapist) under orders of or referred by a health care provider.

b. Treatment by a health care provider on at least one occasion resulting in a regimen of continuing treatment under the supervision of the health care provider.

c. Regimen of Continuing Treatment: Includes a course of prescription medication such as an antibiotic or physical therapy requiring special equipment to resolve or alleviate the health condition. A regimen of treatment does not include taking over-the-counter medications such as aspirin, antihistamines or salves, bed-rest, drinking fluids, exercise, and other similar activities that an individual can initiate without a visit to a health care provider.

C. Pregnancy or pregnancy disability: Any period of incapacity for pregnancy, pregnancy-related illness including severe morning sickness, or for prenatal care or post pregnancy recovery.

D. Chronic conditions requiring treatments: A chronic serious health condition is one which:

a. Requires periodic in-person treatments by a healthcare provider, nurse, or physician's assistant under direct supervision of a healthcare provider.

b. Continues over an extended period of time, including recurring episodes of a single underlying condition.

c. May cause episodic rather than continuing periods of incapacity; for example, asthma, diabetes, epilepsy.

E. Permanent or long-term conditions requiring supervision: A period of incapacity that is permanent or long-term due to a condition for which treatment is potentially ineffective. The employee or family member is under supervision of a health care provider, not necessarily receiving active treatment. Examples are Alzheimer's disease, a severe stroke, the terminal stages of a disease.

F. Multiple treatments (non-chronic conditions): Any period of absence to receive multiple treatments (including any period of recovery) by a health care provider or by a provider of health care services under orders of, or on referral by a health care provider for restorative surgery after an accident or other injury, or for a condition that in the absence of treatment or medical intervention, will likely result in a period of incapacity of more than three consecutive calendar days. For example: chemotherapy or radiation for cancer, physical therapy for severe arthritis, dialysis for kidney disease.

G. None of the above: The patient does not have a serious health condition as described above.

Incapacity: The inability to work, attend school or perform other regular daily activities due to a serious health condition or treatment for or recovery from a serious health condition.

HEALTH CARE PROVIDER CERTIFICATION
** Family Member's Serious Health Condition Form**
Family and Medical Leave
Oregon Department of Corrections

This form is used to provide certification per FMLA and OFLA regulations and law.

Section I: Employee Completes this Section

Employee's name: _____

Patient's name: _____

The patient is my (Please circle one):

spouse	parent	child (age _____)	same sex domestic partner	parent-in-law
grandparent	grandchild	parent of domestic partner	child of a domestic partner (age ___)	

Section II: Health Care Provider Completes this Section

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. **Please be sure to sign the form on the last page and fax completed form to (503) 362-2078.**

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. 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): _____

   _____

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

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.
   If so, 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:

   _____

   _____

   Estimate the employee's dates of absence from work:_____

5. Will the patient require follow-up treatments, including any time for recovery? ___No ___Yes.
   If so, estimate treatment schedule, if any, including the dates of any scheduled appointments and the time required for each appointment, including any recovery period:_____
   _____

   During this time, will the patient need care? __ No __ Yes.
   Explain the care needed by the patient, and why such care is medically necessary: _____
   _____

6. Will the condition cause episodic flare-ups periodically preventing the patient from participating in normal daily activities requiring care on an intermittent or reduced schedule basis? ____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: _____

   _____

   _____

_____ _____

Signature of Health Care Provider **Date**

Please return this form to the patient or FAX to the Department of Corrections Human Resources FMLA/OFLA at (503) 362-2078.

OREGON DEPARTMENT OF CORRECTIONS

Employee Medical Status Report

Fax completed form to: (503) 362-2078

The Oregon Department of Corrections provides a transitional work program for short-term, medically restricted employees who have experienced injury or illness on or off the job. This temporary transitional work program is designed to provide transitional work, as approved by the treating physician and as appropriate for the employee's temporary physical limitations and/or restrictions. Transitional work is normally limited to 30 calendar days with possible extensions after review, and typically should not extend beyond 90 calendar days. The employee is expected to adhere to the treating physician's restrictions. The supervisor monitors for compliance with the transitional work program.

1. Employee Name: _____ Date of Injury/Illness: _____

2. Return to Work Status:

PLEASE CHECK APPROPRIATE STATUS (ONE ONLY):

_____May return to regular job (complete item 7 ONLY) Date: _____

_____May return to transitional/modified duty (complete items 3 – 7) Date: _____

_____May not return to any work (complete items 6 - 7) Estimated date of return:_____

3. Physical Capabilities to Perform Temporary Modified Work

Complete this section ONLY if transitional/modified duty is indicated

Capabilities	YES	NO	Duration and/or Limitations
Can the patient walk?			
Can the patient climb up/down stairs?			
Can the patient sit?			
Can the patient stand?			
Can the patient use arms, wrists and hands for fine manipulation & repetitive movements?			
Can the patient type/use a keyboard?			
Can the patient lift, carry, push, pull up to 20 pounds?			

4. How many hours a DAY can the patient work? _____

5. *Inmate Contact: ☐ None ☐ Limited ☐ Full

***PLEASE Note**: **No inmate contact may prevent patient from returning to work**. Limited inmate contact typically consists of walking past inmates but would not include direct supervision of inmates or assignment to a response team. There is potential for inmate contact within an institution going to and from restrooms, staff dining rooms, or locker rooms. There may also be incidental contact with inmate orderlies at any DOC facility.

6. Date of Next Appointment: _____

7. Physician's Signature: _____ **Date:** _____

Physician's Name (Printed): _____

Address: _____ **Phone:** _____

Distribution: Fax to (503) 362- 2078

EMPLOYEE LEAVE REQUEST

- Employees subject to FLSA shall complete this form **before** leave is taken and **ensure leave has been approved.**
- **In the event of an unplanned absence**, t**he employee shall complete the form immediately upon return to duty**.
- FLSA-exempt employees shall complete this form only for absences which are or may be FMLA/OFLA qualifying (see reverse for qualifying criteria).

Last Name (please print) _____ First _____ M.I. _____

Functional Unit / Institution: _____

☐ Management Service ☐ Executive Service ☐ Represented (Name of Labor Organization) _____

I request _____ hours (total) leave from official duty for the following reason(s): _____

BEGINNING on _____ (Date) at _____ (Hour) ☐AM ☐PM (Check AM/PM) ENDING on _____ (Date) at _____ (Hour) ☐AM ☐PM (Check AM/PM)

I request that my leave be charged as follows: (Please indicate the number of hours for each type of leave requested in the space provided.)

Vacation _____ Sick Leave _____ Personal Leave _____ Comp Time _____ Military Leave _____

Leave Without Pay _____ Bereavement Leave (Relationship) _____ Other _____ (Specify Type of Other Leave)

If this leave is to care for a SERIOUS HEALTH CONDITION or a SICK CHILD, or for PARENTAL LEAVE, check the appropriate spaces in the boxed area below: (See reverse for explanation of a serious health condition and FMLA/OFLA leave.)

™ ***You must give 30 days advance notice unless an emergency exists***.

- ☐ Your serious health condition (see definition on back) ..... FMLA, OFLA
- ☐ Family member (son/daughter, parent, legal spouse) with a serious health condition (see definition on back)..... FMLA, OFLA
- ☐ Parent-in-law, grandparent, grandchild or same-sex domestic partner with a serious health condition (see definition on back) OFLA
- ☐ Sick child who does not have a serious health condition, but requires home care ..... OFLA
- ☐ Pregnancy (includes prenatal care, childbirth, and recovery) ..... FMLA, OFLA
- ☐ Care for a newborn, newly adopted, or newly placed foster child under age 18, unless incapable of self-care due to disability.....FMLA, OFLA.

Is this a previously approved FMLA/OFLA qualifying condition? ☐ Yes ☐ No

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

If yes, name of spouse and Agency where employed. _____

If approved for FMLA/OFLA, you must attempt to schedule leave to be as least disruptive to the employer.

Medical certification and/or fitness-for-duty certification may be required. (For sick child leave, medical certification may be required after three days of leave.)

FMLA/OFLA Coordinators approve FMLA/OFLA Leave. Supervisor signature does not guarantee FMLA/OFLA approval.

Employee Signature _____ Date _____ Supervisor Signature _____ Date _____

☐ APPROVED ☐ NOT APPROVED

Approval is contingent on staff having adequate leave accrual.

Section Head Signature _____ Date _____

Reason, if not approved: _____

Staff Deployment Notes: _____ Updated: _____

ATTENTION Supervisors/Managers: If the leave checked above is included in the boxed area, please ***immediately*** forward a copy of this leave request form to your assigned FMLA/OFLA Coordinator. The leave may qualify as FMLA leave which means the employee's medical-dental insurance may be paid while on leave without pay and the leave will be counted as part of the 12 weeks of FMLA leave eligibility.

A serious health condition under the FMLA means an illness, injury, impairment, or physical or mental condition that includes at least one of the following:

- **Inpatient care** in a hospital, hospice or residential medical-care facility, including any period of incapacity, or any subsequent treatment in connection with such inpatient care; OR

- **Continuing treatment** by a health care provider which includes one of the following:

  - Incapacity due to a serious health condition lasting more than three (3) consecutive calendar days; and subsequent treatment or incapacity relating to the same condition which includes either two or more treatments administered or supervised by a health care provider, or at least one treatment with a continuing regimen of treatment;

  - Incapacity due to pregnancy or absence for prenatal care;

  - Incapacity or treatment thereof due to a chronic serious health condition, which requires periodic treatment by a health care provider and continues over an extended period. (Incapacity may be episodic versus continuous, e.g., asthma, diabetes, epilepsy, etc.),

  - Incapacity which is permanent or long-term due to a condition for which treatment is not effective (e.g.; severe stroke, Alzheimer's, or the terminal stages of a disease); **OR**

  - Absence to receive multiple treatments from a health care provider for restorative surgery and recovery therefrom, following an injury or accident, or for a condition that would likely cause incapacity for at least three consecutive days if left untreated (e.g. chemotherapy or radiation for cancer, physical therapy for arthritis, and dialysis for kidney diseases.)

Incapacity means inability to work or perform other daily activities due to treatment or recovery from a serious health condition.

Purpose of Leave: To care for your own serious health condition; a family member's serious health condition; or following the birth, adoption or foster placement of a child under age 18, unless incapable of self-care due to disability.

Eligibility for Leave: You must have at least 12 months of employment with the State of Oregon (need not be consecutive service); during your last 12 months of employment prior to the leave request, you must have worked for at least 1,250 hours; AND leave must be for a qualifying event.

Maximum Leave: 12 weeks in a 12-month period. (If the State of Oregon employs both parents, their combined parental leave is limited to the 12 weeks.)

A serious health condition under OFLA means one of the following:

- An illness, injury, impairment or physical or mental condition that requires inpatient care in a hospital, hospice or residential medical care facility;

- An illness, disease or condition that poses imminent danger of death, is terminal with a reasonable possibility of death in the near future, or requires constant care; OR

- Disability due to pregnancy or absence for prenatal care.

Purpose of Leave: Parental Leave: To care for your newborn, newly adopted or newly placed foster child who is under the age of 18, unless incapable of self-care due to disability; Serious Health Condition Leave: To care for your own serious health condition if it prevents you from performing at least one essential function of your job, or to care for a family member's serious health condition; Sick Child Leave: To care for your own child due to an illness, injury or condition that is not a serious health condition, but requires home care.

Eligibility for Leave: For parental leave you must have been employed for at least the 180 days immediately preceding the start date of the leave; for all other leave you must also have worked an average of at least 25 hours per week during the 180 days; AND leave must be for a qualifying event.

Maximum Leave: 12 weeks in a one-year period. An additional 12 weeks is available for a disabling illness, injury or condition related to pregnancy or childbirth. An employee who takes the full 12 weeks of Parental Leave may also take 12 weeks of Sick Child Leave.

Medical certification may be required for leave due to a medical condition. Medical certification of fitness for duty may be required upon an employee's return form FMLA due to his/her own serious health condition.

If leave qualifies under the FMLA, OFLA, and/or contractual benefit provisions, its use is counted against applicable entitlements.

Employees may be required to exhaust all accrued leave in accordance with collective bargaining agreements and personnel policies prior to being placed on leave without pay during FMLA/OFLA leave.

Going out on medical leave

We understand that you may be going out on medical/extended leave at this time. There are a few things surrounding your benefits and pay that we would like to bring to your attention.

FMLA and OFLA are not optional. The laws require the agency to provide these entitlements.

1. **Use of sick and vacation leave**.
    a. If going out under FMLA and short term disability (STD) you may decide the type of leave usage. You can choose to use paid or unpaid leave, and decide when use of paid leave begins. Once you have started using paid leave, each leave must be used in a block until exhausted and there cannot be breaks in time between leave types.
    b. Once in unpaid leave (LWOP), you cannot go back and use any paid leave, unless you are covered under FMLA.
    c. Use of sick leave is reported to Standard Insurance for the short term claim. Standard will evaluate your wages and pay you the difference between a regular week's wages and what you have received. If you have sick leave for the full week, Standard will pay a minimum of $25.00 per week.
    d. Use of vacation, personal business, compensatory time are reported to Standard, but are not included in their payment calculation. You will receive a full check from Standard.
    e. You may choose to bank (save) some leave time as allowed per your bargaining agreement. If banking or saving paid leave, you will not be eligible for Hardship Donations.

2. **Use of Short/Long Term Disability**
    a. If using short term disability, you will want to start the claim as soon as possible. You can start a claim by calling The Standard at 800-842-1707. DOC will complete their portion of the report when we receive notification from The Standard.
    b. The first seven days are not paid; this is Standard's evaluation time. If the claim is due to an accident, Standard will pay from the first day. Once the claim has been accepted, they will pay on a weekly basis.
    c. What Standard pays you is based on what pay, if any, you receive from DOC.
        i. If you are receiving wages from DOC for payment of sick leave, Standard will only pay a percentage of the week, with a minimum of $25.00, depending on use of sick leave.
        ii. In order for The Standard to pay you the full amount, you must be using leave other than paid sick leave or be in LWOP.
    d. Long Term Disability, if enrolled, will automatically follow STD. If you have chosen the 180 day waiting period for long term disability, you will have at least a 3 month gap before long term disability becomes effective and short term disability ends.
    e. There is no need to complete separate forms after short term disability ends. The Standard will request specific information as needed.

3. **Hardship Donations**
    a. Hardship eligibility is reviewed and approved by Human Resources if you qualify. Other employees may donate vacation time, which will be converted to sick leave for you to use, or cover insurance premiums. There is no guarantee the full request will be met or all of the leave time covered.

b. Hardship donations can only be requested once all leave has been exhausted. If you are banking leave time, you will not be eligible for hardship donations until the leave is exhausted.

4. Core Benefits

a. Medical, Dental, Vision, and Basic Life Insurance are considered the core benefits provided by the state. While under protected leave (FMLA/SAIF/Military) the state will continue to pay its portion toward premium payments. You may also be eligible under the Affordable Care Act to have DOC continue to pay its premiums share.You are still responsible to continue payment of your share of the premium.
b. If you are receiving a check from DOC, and are paid a minimum of 80 hours, your premium payments are automatically paid from your wages.
c. If you fall below 80 paid hours or are in LWOP, a letter will be mailed to you detailing the coverage benefits you have, the amount necessary to maintain coverage, and how to make the necessary payments each month. Please contact payroll with questions.
d. If you choose not to continue core insurance coverage while you are out, you need to request in writing to terminate coverage, but it will then affect any medical services while you're out.

5. Optional Insurance Benefits

a. Continued payment and coverage for the following are handled the same as the core benefits, except these may be paid for up to 1 year as long as your remain employed, without the FMLA/SAIF/Military/ACA stipulation.
    i. Accidental Death and Dismemberment
    ii. Flexible Spending Account (Health and Dependent) can be prepaid with prior approval or reenrolled in when you return to work.
    iii. Domestic Partner Tax (if the partner continues to be covered for core benefits)
    iv. UNUM, Long Term Care Insurance
    v. Assurant Insurance
    vi. Optional Life Insurance, self and spouse and/or partner
    vii. Dependent Life
    viii. Short Term and Long Term Disability – if you currently have an active claim, no premiums are due while the claim is open. These are only payable for 90 days.
b. If you are receiving a check from DOC, and are paid a minimum of 80 hours, your premium payments are automatically recovered from your wages.
c. If you fall below 80 hours or are in LWOP, a letter will be mailed to you detailing the optional coverage benefits you have, the amount necessary to maintain coverage, and how to make the necessary payments each month. Please contact payroll at the number above with questions.
d. If you choose not to continue optional insurance coverage while you are out, you need to request in writing to terminate coverage, but it will then affect the use of disability coverage while you're out.

EMPLOYEE RIGHTS AND RESPONSIBILITIES UNDER THE FAMILY AND MEDICAL LEAVE ACT

Basic Leave Entitlement

FMLA requires covered employers to provide up to 12 weeks of unpaid, job-protected leave to eligible employees for the following reasons:

- for incapacity due to pregnancy, prenatal medical care or child birth,
- to care for the employee's child after birth, or placement for adoption or foster care,
- to care for the employee's spouse, son, daughter or parent, who has a serious health condition; or
- for a serious health condition that makes the employee unable to perform the employee's job

Military Family Leave Entitlements

Eligible employees whose spouse, son, daughter or parent is on covered active duty or call to covered active duty status may use their 12-week leave entitlement to address certain qualifying exigencies. Qualifying exigencies may include attending certain military events, arranging for alternative childcare, addressing certain financial and legal arrangements, attending certain counseling sessions, and attending post-deployment reintegration briefings.

FMLA also includes a special leave entitlement that permits eligible employees to take up to 26 weeks of leave to care for a covered servicemember during a single 12-month period. A covered servicemember is: (1) a current member of the Armed Forces, including a member of the National Guard or Reserves, who is undergoing medical treatment, recuperation or therapy, is otherwise in outpatient status, or is otherwise on the temporary disability retired list, for a serious injury or illness*, or (2) a veteran who was discharged or released under conditions other than dishonorable at any time during the five-year period prior to the first date the eligible employee takes FMLA leave to care for the covered veteran, and who is undergoing medical treatment, recuperation, or therapy for a serious injury or illness.*

***The FMLA definitions of "serious injury or illness" for current servicemembers and veterans are distinct from the FMLA definition of "serious health condition".**

Benefits and Protections

During FMLA leave, the employer must maintain the employee's health coverage under any "group health plan" on the same terms as if the employee had continued to work. Upon return from FMLA leave, most employees must be restored to their original or equivalent positions with equivalent pay, benefits, and other employment terms.

Use of FMLA leave cannot result in the loss of any employment benefit that accrued prior to the start of an employee's leave.

Eligibility Requirements

Employees are eligible if they have worked for a covered employer for at least 12 months, have 1,250 hours of service in the previous 12 months*, and if at least 50 employees are employed by the employer within 75 miles.

***Special hours of service eligibility requirements apply to airline flight crew employees.**

Definition of Serious Health Condition

A serious health condition is an illness, injury, impairment, or physical or mental condition that involves either an overnight stay in a medical care facility, or continuing treatment by a health care provider for a condition that either prevents the employee from performing the functions of the employee's job, or prevents the qualified family member from participating in school or other daily activities.

Subject to certain conditions, the continuing treatment requirement may be met by a period of incapacity of more than 3 consecutive calendar days combined with at least two visits to a health care provider or one visit and a regimen of continuing treatment, or incapacity due to pregnancy, or incapacity due to a chronic condition. Other conditions may meet the definition of continuing treatment.

Use of Leave

An employee does not need to use this leave entitlement in one block. Leave can be taken intermittently or on a reduced leave schedule when medically necessary. Employees must make reasonable efforts to schedule leave for planned medical treatment so as not to unduly disrupt the employer's operations. Leave due to qualifying exigencies may also be taken on an intermittent basis.

Substitution of Paid Leave for Unpaid Leave

Employees may choose or employers may require use of accrued paid leave while taking FMLA leave. In order to use paid leave for FMLA leave, employees must comply with the employer's normal paid leave policies.

Employee Responsibilities

Employees must provide 30 days advance notice of the need to take FMLA leave when the need is foreseeable. When 30 days notice is not possible, the employee must provide notice as soon as practicable and generally must comply with an employer's normal call-in procedures.

Employees must provide sufficient information for the employer to determine if the leave may qualify for FMLA protection and the anticipated timing and duration of the leave. Sufficient information may include that the employee is unable to perform job functions, the family member is unable to perform daily activities, the need for hospitalization or continuing treatment by a health care provider, or circumstances supporting the need for military family leave. Employees also must inform the employer if the requested leave is for a reason for which FMLA leave was previously taken or certified. Employees also may be required to provide a certification and periodic recertification supporting the need for leave.

Employer Responsibilities

Covered employers must inform employees requesting leave whether they are eligible under FMLA. If they are, the notice must specify any additional information required as well as the employees' rights and responsibilities. If they are not eligible, the employer must provide a reason for the ineligibility.

Covered employers must inform employees if leave will be designated as FMLA-protected and the amount of leave counted against the employee's leave entitlement. If the employer determines that the leave is not FMLA-protected, the employer must notify the employee.

Unlawful Acts by Employers

FMLA makes it unlawful for any employer to:

- interfere with, restrain, or deny the exercise of any right provided under FMLA; and
- discharge or discriminate against any person for opposing any practice made unlawful by FMLA or for involvement in any proceeding under or relating to FMLA.

Enforcement

An employee may file a complaint with the U.S. Department of Labor or may bring a private lawsuit against an employer.

FMLA does not affect any Federal or State law prohibiting discrimination, or supersede any State or local law or collective bargaining agreement which provides greater family or medical leave rights.

FMLA section 109 (29 U.S.C. § 2619) requires FMLA covered employers to post the text of this notice. Regulation 29 C.F.R. § 825.300(a) may require additional disclosures.

BUREAU OF LABOR AND INDUSTRIES

Brad Avakian, Commissioner

Oregon FAMILY LEAVE ACT

NOTICE TO EMPLOYERS AND EMPLOYEES

The Oregon Family Leave Act, passed by the 1995 Legislature, requires employers of 25 or more employees in Oregon to provide their workers with job protected leave to care for themselves or family members in cases of illness, injury, childbirth or adoption.

When Can an Employee Take Family Leave?

Employees can take family leave for the following reasons:

- **Parental Leave** during the year following the birth of a child or adoption or foster placement of a child under 18 or a child 18 or older if incapable of self-care because of a mental or physical disability. Parental leave includes leave to effectuate the legal process required for foster placement or adoption.
- **Serious health condition leave** for the employee's own serious health condition or to care for a spouse, parent, child, parent-in-law, grandparent, grandchild, same-gender domestic partner or parent or child of same-gender domestic partner with a serious health condition. **NOTE:** Does not include an employee unable to work due to a compensable Workers Compensation injury.
- **Pregnancy disability leave** (a form of serious health condition leave) taken by a female employee for an incapacity related to pregnancy or childbirth, occuring before or after the birth of a child, or for prenatal care.
- **Sick child leave** taken to care for an employee's child with an illness, condition or injury that requires home care but is not a serious health condition.
- **Oregon Military Family Leave** is taken by the spouse or same-gender domestic partner of a service member who has been called to active duty or notified of an impending call to active duty or is on leave from active duty during a period of military conflict.

Who is Eligible?

- To be eligible for leave, workers must be employed for the 180 day calendar period immediately preceding the leave and have worked at least an average of 25 hours per week during the 180 day period.
- **Exception 1:** For parental leave, workers are eligible after being employed for 180 calendar days, without regard to the number of hours worked.
- **Exception 2:** For Oregon Military Family Leave, eligible workers must work for an employer an average of at least 20 hours per week, without regard to the number of days worked.

How Much Leave Can an Employee Take?

- Employees are generally entitled to a maximum of 12 weeks of family leave within the employer's 12-month leave year.
- A woman using pregnancy disability leave is entitled to 12 additional weeks of leave in the same leave year for any qualifying OFLA purpose.
- A man or woman using a full 12 weeks of parental leave is entitled to take up to 12 additional weeks for the purpose of sick child leave.
- A spouse or same-gender domestic partner of a service member is entitled to a total of 14 work days of unpaid leave per deployment after the military member has been notified of an impending call or order to active duty before deployment and when the military member is on leave from deployment.

What Notice is Required?

- Employers may require employees to give 30 days notice in advance of leave, unless the leave is taken for an emergency. Employees must follow the employer's policy. Employers may require that notice is given in writing and may require an explanation of the need for leave. In an emergency, employees must give verbal notice within 24 hours of starting a leave.

Is Family Leave Paid or Unpaid?

- Although Family Leave is generally unpaid, employees are entitled to use any accrued paid vacation, sick or other paid leave.

How is an Employee's Job Protected During a Leave?

- Employers must return employees to their former jobs or to equivalent jobs if the former position no longer exists. However, employees on OFLA leave are still subject to nondiscriminatory employment actions such as layoff or discipline that would have been taken without regard to the employee's leave.

Eligible employees who have been denied leave, disciplined or retaliated against for requesting or taking leave, or have been denied reinstatement to the same or equivalent position when they returned from a leave or requested leave may file a complaint with the Bureau of Labor and Industries, Civil Rights Division.

For additional information, please call the nearest office of the Bureau of Labor and Industries:

- **Eugene**.....541-686-7623
- **Salem**.....503-378-3292
- **Portland**....971-673-0761

Employer Assistance:
- 971-673-0824

Website: www.oregon.gov/boli

Or Write:
Bureau of Labor and Industries
Civil Rights Division
800 NE Oregon St Ste. 1045
Portland, OR 97232

This is a summary of Oregon's laws relating to Family Leave Act (OFLA). It is not a complete text of the law.

January 2012

THIS INFORMATION MUST BE POSTED IN A CONSPICUOUS LOCATION