Request for Protected Leave (FMLA/OFLA/PFML) Fern Ridge School District

This request is intended for employees needing to request protected leave under Family Medical Leave Act (FMLA, Oregon Family Leave Act (OFLA) or Paid Family Medical Leave (PFMLI). If you have filed or intend to file a PFMLI you only need to complete the Request for Protected Leave form (attached) and then contact The Hartford at 1-888-301-5615. If you are not filing for PFMLI, you will need to submit this form as well as the Heath Care Provider Certification form (attached).

1. Complete the attached form in full; obtain your administrators/supervisors signature.
2. Bring or fax the form to the Payroll Office (541)935-8222.
3. Complete and provide The Health Care Provider Certification to the Payroll Office within 15 calendar days of your request, or before your leave begins. If you are filing a PFMLI claim, The Hartford has their own Health Care Certification for that will need to be completed, not ours.

Board Policies Regarding FMLA/OFLA/PFMLI: https://policy.osba.org/fernridg/G/index.asp

Request for Protected Leave (FMLA/OFLA/PFML) Fern Ridge School District

This request is intended for employees needing to request protected leave under Family Medical Leave Act (FMLA, Oregon Family Leave Act (OFLA) or Paid Family Medical Leave (PFMLI). If you have filed or intend to file a PFMLI claim, you only need to complete this form and then contact The Hartford at 1-888-301-5615. If you are not filing for PFMLI, you will need to submit this form as well as the Certification of Health (attached).

1.Complete this form in full; obtain your administrators/supervisors signature.
2.Bring or fax the form to the Payroll Office (541)935-8222.
3.Complete and provide The Health Care Provider Certification to the Payroll Office within 15 calendar days of your request, or before your leave begins. If you are filing a PFMLI claim, The Hartford has their own Health Care Certification for that will need to be completed.

-Where the need for leave may be anticipated, written request for protected leave must be made, if practical, at least 30 days prior to the date the requested leave is to begin.
-If your leave was unforeseeable you must give the district oral notice as soon as practicable and provide the Payroll Office with the completed form within 3 days of returning to work.

Failure to request leave in a timely manner could result in either the leave being postponed or the amount of leave available reduced up to three weeks.

Name: Anticipated Leave Start Date:

Position: Anticipated Leave End Date:

Have you taken family leave in the past 12 months? ☐ Yes ☐ No

Have you filed or will you be filing a PFML claim with The Hartford? ☐ Yes ☐ No
If you marked "Yes" please select an option below:

☐ I **would like to use my available district paid leave** (sick, personal, vacation) to reveive 100% of my normal wage in conjunction with benefits paid through PFML issued by The Harford.

☐ I **do not want to use any of my available district paid leave** (sick, personal, vacation) while receiving benefits through PFML issued by The Hartford.

I understand that it is my responsibility to apply and provide the necessary documentation to The Hartford in order to qualify for payment of PFMLI benefits. Additionally, I understand that the district will process all payroll and leave benefits based on the choice I have indicated above. Furthermore, I acknowledge that if my claim for PFMLI benefits through The Hartford has not been approved at the time of payroll processing, the district will deduct my available paid leave (sick, personal, vacation) or dock my pay accordingly for the time taken off, if no paid leave is available. The district will also reimburse any previously charged leave if a claim for PFMLI benefits through The Hartford is approved.

Frequency of Leave: ☐ Continuous ☐ Intermittent

Reason for Leave:

◯ Employee's own serious health condition ◯ Serious health condition of a family member
◯ Parental Leave - Birth/Adoption/Foster Placement of a child ◯ Pregnancy Disability ◯ Sick Child Lv. non-serious
◯ Military Leave ◯ Military Caregiver ◯ Bereavement ◯ Safe Leave

I understand that the district requires me to use any available accrued sick leave, personal leave or vacation days or other paid time established by Board policy(ies) and/or negotiated agreement in the order specified by the district, and before taking leave without pay, for FMLA/OFLA.

If my request for leave is approved, it is my understanding that without an authorized extension when the need for an extension could be anticipated; I must report to duty on the first work day following the date my leave is scheduled to end. I understand that failure to do so will constitute unequivocal notice of my intent not to return to work and the district may terminate my employment. (A fitness-for-duty certification may be required).

I have been provided a copy of the district's family and medical leave policy and a copy of my rights and responsibilities under FMLA/OFLA/PFMLI.

Signature of Employee:_____ Date:_____

Administrator Signature:_____ Date:_____

HOW TO FILE FOR OREGON PAID FAMILY AND MEDICAL LEAVE INSURANCE WITH CONFIDENCE

Your OR PFMLI claim is managed by The Hartford. It's a user-friendly benefit that helps provide essential support services while you're away from your workplace.

Lane County School District 28J

135140

Follow these steps to file a claim with The Hartford:

STEP 1: KNOW WHEN IT'S TIME TO FILE A CLAIM

If you're absent from work, we can advise you on when to file a claim.

- If your absence is scheduled, file your claim within 30 days of your last day of work. (For example, an upcoming hospital stay)
- If your absence is unscheduled, follow your employer's call out policy and file your claim as soon as possible.

STEP 2: HAVE THIS INFORMATION READY

- Name, address, policy number, and other key identification information.
- Name of your department and last anticipated day of active full-time work.
- The nature of your claim.
- When applicable, your treating physician's name, address, phone and fax numbers.

STEP 3: FILE YOUR CLAIM

With your information handy, file a claim by: Calling The Hartford at **888-301-5615** ; or Completing the claim form provided by your employer with input from your employer and the provider. Mail or fax the documentation to:

The Hartford
PO Box 14869
Lexington, KY 40512
Fax Number: 833-357-5153

You'll be assisted by a caring professional who'll take your information, answer your questions and help you file your claim or process your leave request.

Please cut here and keep in your wallet.

TO FILE AN OR PFMLI CLAIM

888-301-5615
Policy Number: 135140

If you're absent from work, we can advise you on when to file a claim. If your absence is scheduled, such as an upcoming hospital stay, call us within 30 days of your last day of work. If unscheduled, please call us as soon as possible.

THE HARTFORD

GET SUPPORTIVE ASSISTANCE

After your claim has been filed, we may be in touch to check your progress, answer questions or obtain additional information from you.

Our goal is to offer a smooth and hassle-free experience until you return to work. Feel free to call us with anything that's on your mind. We're here to help.

Product	**OR PFMLI**
Employer Name	Lane County School District 28J
Policy Number	135140
Phone Number	888-301-5615

FOR MORE INFORMATION, PLEASE CONTACT THE HARTFORD'S TOLL-FREE NUMBER 888-301-5615

THE HARTFORD

Business Insurance
Employee Benefits
Auto
Home

Statutory Paid Family and Medical Leave Form Series included GBD-1858 PFML (OR).

1984850 08/23

Please cut here and keep in your wallet.

WHEN YOU CALL, THE HARTFORD WILL ASK YOU TO PROVIDE

Name, address, policy number and other key identification information.

- Name of your department and last day of active work.
- The nature of your claim.
- Your treating physician's name, address, phone and fax numbers.

This card is not proof of insurance
1984850a 08/23

Family Leave in Oregon – Effective January 1, 2025

****This is an informational tool only – this is not legal advice****

	FMLA	OFLA	Paid Leave Oregon	Stacking/Concurrent[1]
Birth of Child	Up to 12 weeks ✓		Up to 12 weeks ✓	FMLA & PLO concurrent
Placement of foster or adopted child	Up to 12 weeks ✓		Up to 12 weeks ✓	FMLA & PLO Concurrent
Pregnancy Disability	Up to 12 weeks ✓	Up to 12 weeks ✓ Definition includes period of disability due to fertility/infertility treatments or pregnancy termination	Up to 2 weeks ✓	OFLA & PLO stackable FMLA & PLO concurrent
Serious Health Condition of Employee	Up to 12 weeks ✓		Up to 12 weeks ✓	FMLA & PLO concurrent
Serious Health Condition of Family	Up to 12 weeks ✓ Defined as child, spouse, or Parent.	Except for child who is cared for in the home (see Sick Child Leave)	Up to 12 weeks ✓ Broad definition of family[2]	FMLA & PLO concurrent
Bereavement Leave		✓ Up to 2 weeks per death / four weeks in a leave year		N/A
Sick Child Leave	May be covered under "serious health condition of family member" category	✓ • Home care due to illness, injury, or condition • Public health closure of school or daycare	May be covered under "serious health condition of family member" category	Stackable with other OFLA leave and PLO
Safe Leave			Up to 12 weeks ✓	N/A
Use of Accrued Leave	✓	✓	Up to 100% of wages ✓	

[1] "Concurrent" means an absence may be covered by both leave balances at the same time. "Stackable" means an employee may exhaust one leave type and then continue protected leave using another leave type.

[2] Defined as child, spouse/domestic partner, parent, sibling/stepsibling or their partner, grandparent or their partner, grandchild, or "any individual related by blood or affinity whose close association with a covered individual is the equivalent of a family relationship." ORS 657B.010(19)(h).

Oregon and Federal Family and Medical Leave
Health Care Provider Certification

This form is to be completed by physician or other health care provider and returned to:
☒ the employee, or ☐ the employer (below):

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

Employee's Name: _____

Patient's Name (if different from employee)**:** _____

1. On the reverse of this sheet is a description of various "serious health condition" categories that qualify under the Family and Medical Leave Acts. Please check appropriate category or categories:

☐ 1-Hospital care ☐ 3-Pregnancy and/or prenatal care ☐ 5-Perm/long-term condition requiring supervision
☐ 2-Absence plus treatment ☐ 4-Chronic condition requiring treatment ☐ 6-Multiple treatments (non-chronic condition)

2. Provide a description of the medical facts that support your certification and explain how they meet the criteria of the category: _____

_____

3. Approximate date condition began and probable duration: from __/__/__ through __ /__/__

4. Probable duration of patient's present incapacity (if different): from ___/___/___ through __ /___/___

5. If this is a chronic condition or pregnancy, is the patient presently incapacitated (see reverse side for definition)?

☐ Yes ☐ No If yes, duration and frequency of episodes of incapacity: _____

6. 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? ☐ Yes ☐ No If yes, duration: _____

Frequency: ☐ One to two days per month ☐ Two to three days per month ☐ Three to four days per month

☐ Other: Please explain how the employee will use leave intermittently or work a less than full-time schedule, being as specific as possible including frequency and duration of absences:

_____

7. If the patient requires a regimen of treatment, what is the nature of and description of the treatments, estimated number of treatments, and intervals between treatments (see reverse side for definition)? _____

_____

What are the actual or estimated dates of visits for treatment, or frequency of visits for treatment? _____

What is the duration of each treatment and any period required for recovery? _____

8. If this certification relates to the employee's seriously ill family member(s), also complete the following:

a. Does the patient require assistance for basic medical or personal needs, safety, or for transportation? ☐ Yes ☐ No

b. If no, would the employee's presence to provide psychological comfort be beneficial or assist in the patient's recovery? ☐ Yes ☐ No

c. If the patient will need care only intermittently or on a part-time basis, please indicate the probable duration and frequency of this need: _____

_____ _____
Printed Name of Physician/ Practitioner *Date Signed*

_____ _____
Signature of Physician/ Practitioner *Type of Practice/ Field of Specialization*

_____ _____
Address *Phone Number*

HEALTH CARE PROVIDER CERTIFICATION form (continued)

Federal and Oregon Family and Medical Leave Acts

Definition of a "Serious Health Condition":

A "serious health condition" is defined as an illness, impairment, physical or mental condition that involves one of the following:

1. 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 consequent to such inpatient care.

2. Absence plus treatment –
A period of incapacity of more than three consecutive calendar days (including any period of incapacity or subsequent treatment relating to the same condition), that also involves:

(a) Treatments two or more times by a licensed healthcare provider, nurse, or physician's assistant under direct supervision of a healthcare provider, or by a provider of healthcare services (e.g., physical therapist) under orders of, or on referral by, a healthcare provider, ***or***

(b) Treatment by a healthcare provider on at least one occasion which results in a regimen of continuing treatment under supervision of the healthcare provider.

(1) Treatment includes examinations to determine if a serious health condition exists and evaluations of the condition. Treatment DOES NOT include routine physical, dental, or eye examinations.

(2) A regimen of continuing treatment includes, for example, a course of prescription medication (e.g., an antibiotic) or therapy requiring special equipment to resolve or alleviate the health condition. A regimen of treatment DOES NOT include the taking of over-the-counter medications such as aspirin, antihistamines, or salves; or bed-rest, drinking fluids, exercise, or any other similar activities that can be initiated without a visit to a healthcare provider.

3. Pregnancy –
Any period of incapacity due to pregnancy, pregnancy-related illness, or for prenatal care.

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

(a) Requires periodic visits for treatment 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); and

(c) May cause episodic rather than continuing periods of incapacity (e.g., asthma, diabetes, epilepsy, etc.)

5. Permanent/ long-term conditions requiring supervision –
A period of incapacity that is permanent or long-term due to a condition for which treatment may not be effective. The employee or family member must be under the continuing supervision of, but need not be receiving active treatment by, a healthcare provider. Examples include Alzheimer's, a severe stroke or the terminal states of a disease.

6. Multiple treatments (non-chronic conditions) –
Any period of absence to receive multiple treatments (including any period of recovery therefrom) by a healthcare provider or by a provider of healthcare services under orders of, or on referral by, a healthcare provider, either of restorative surgery after an accident or other injury, or for a condition that would likely result in a period of incapacity of more than three consecutive calendar days in the absence of medical intervention or treatment, such as cancer (chemotherapy, radiation, etc.), severe arthritis (physical therapy), kidney disease (dialysis).

Definition of "Incapacitated": Inability to work, attend school, or perform other regular daily activities due to the serious health condition, treatment therefore, or recovery therefrom.

Directions regarding "Regimen of treatment" (question 5): If the patient is under your supervision, provide a general description of such regimen, such as prescription drugs or physical therapy requiring special equipment. If the treatments will be provided by another provider of health services, such as a physical therapist, please state the nature of the treatments.