LEAVE REQUEST

Employee Name: _____ Date: _____

START TIME/END TIME

LEAVE REQUESTED

Date(s) _____ **Hours** _____ Personal Vacation Med/Sick Unpaid Professional _____

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Unpaid leave is only available at the discretion of your supervisor

Under state law, an employee requesting OFLA leave shall provide at least *30 DAYS NOTICE* prior to the leave date if foreseeable. The employee must make a reasonable effort to schedule treatment, including intermittent leave and reduced leave, so as not to unduly disrupt the operation of the district. You may qualify for OFLA leave if you have worked at least 180 days and an average of 25 hrs. a week.

EMPLOYEE: COMPLETE THIS SECTION ONLY IF REQUESTING OFLA LEAVE

1) Please check reason for request

- ☐ Your serious health condition**
- ☐ Family members with serious health condition**
- ☐ Child requiring home care
- ☐ Pregnancy: Expected date of birth_____ Leave to start_____ Expected return date_____
- ☐ Care for a newborn child
- ☐ Placement/adoption or foster care: Leave to start
- ☐ Parent-in-law with condition that poses imminent danger of death, is terminal or requires constant care
- ☐ Qualifying Exigency for Military Family leave

2) Do you have a spouse who works LVCS who is requesting time off for the same purpose?

☐ Yes No *(Restrictions may apply. OAR 839-009-0240 Contact personnel office.)*

3) If you are requesting an altered or reduced work schedule for medical reasons, either for yourself or family members, please indicate your scheduling needs: *(Attach a separate sheet, if necessary)*

NOTE: In some instances it may be necessary for LVCS to ask for additional information to determine whether the leave is OFLA qualifying. Any disclosure of medical information will be kept in a confidential file and will be used only to determine eligibility for OFLA and to track leave.

**(certification may be required)

Employee Signature: _____ **Date:** _____

Supervisor's Signature: _____ Date Employee Notified of approval/denial