

CITY OF SALEM FMLA/OFLA LEAVE REQUEST FORM

Last Name _____ First Name _____ Middle Initial _____ Department/Division _____

Mailing Address Street or PO BOX _____ City, State _____ Zip _____

Employee Number _____ Work Phone _____ Home Phone _____

Last Day _____ Anticipated _____
Worked: _____ Leave Dates: From: _____ To: _____ New Application ____ Revised ____

REASON FOR FMLA/OFLA LEAVE

____ **Employee's Serious Health Condition:**
Complete and return Medical Certification Form

____ **Birth of a Child/Adoption or Placement of a Child:**
Anticipated delivery date of child: _____
Anticipated date of physical custody of child: _____

____ **Care of Seriously Ill Family Member: (Complete and return Medical Certification Form)**
Name of seriously ill family member: _____
Relationship to employee: _____
If child of employee, date of birth: _____
What care will you provide? _____

Is leave requested on an intermittent basis?: ___ No ___ Yes If yes, attach a projected schedule leave required including frequency/duration (for example: 1 day per month for treatment)

Does your Spouse or same sex domestic partner work for the City of Salem? If so,
Spouse/Same Sex Domestic Partner Name: _____ Department/Division: _____

I understand that my leave may be delayed until the **Medical Certification Form** is returned, if applicable. I understand that in the case of my own serious health condition, I may not be permitted to resume my position with the City until I provide a completed **Return to Work Release Form**. City policy requires employees use all accrued sick leave followed by other accrued leaves before a period of unpaid leave. I agree that while I am on leave, I will continue to pay my share of any insurance premiums, if applicable, unless I elect to discontinue coverage. I also agree that that if I fail to return to work at the end of the leave period, I will reimburse the City for its share of City provided health benefits during my leave, unless I fail to return to work because of the continuation, recurrence, or onset of my own serious health condition, or by other circumstances beyond my control. Finally, I understand that if I do not return to work on the date indicated above (or another date as specified by me and agreed to by the City), my employment may be terminated by the City as of the date my leave expires.

Employee's Signature: _____ Date: _____
Supervisor's Signature: _____ Phone Number: _____
Printed Name of Supervisor: _____ Date: _____

TO BE COMPLETED BY BENEFITS MANAGER, BENEFITS ASSISTANT OR HUMAN RESOURCES DIRECTOR

Employee Eligible: ___ FMLA ___ OFLA

___ APPROVED ___ PROVISIONALLY APPROVED ___ NOT APPROVED

Designated as Family Medical Leave (FMLA) ___ Yes ___ No Beginning Date: _____ End Date: _____

Designated as Oregon Family Leave (OFLA) ___ Yes ___ No Beginning Date: _____ End Date: _____

Approval Signature: _____ Date: _____

MEDICAL CERTIFICATION FORM

(To be completed by Healthcare Provider)

1. Employee's Name: _____
2. Patient's Name, if different from employee: _____
3. The attached sheet describes what is meant by a "serious health condition" under the Federal and Medical Leave Act and the Oregon Family Leave Act. Does the patient's condition¹ qualify under any of the categories described? If so, please check the applicable category. See attached definitions as a guide.

(1) ___ (2) ___ (3) ___ (4) ___ (5) ___ (6) ___ (7) ___, or None of these ___
4. Describe the **medical facts** which support your certification, including a brief statement as to how the medical facts meet the criteria of one of the above categories.
5. a. Date the condition commenced: _____

Probable duration of condition: _____

Is Patient presently incapacitated²? ___ Yes ___ No

If yes, what is the probable duration of the incapacity? _____
- b. If the condition is a chronic condition as described in #4 of attached definitions or pregnancy, what is the likely frequency of episodes and duration of incapacity?

Frequency of episodes: _____

Duration of episodes: _____
- c. Will it be necessary for the employee to work only **intermittently or to work on a less than regular schedule** as a result of the condition, including treatment described in Item #6 of attached definitions?
___ Yes ___ No

If yes, give the probable duration: _____

Probable frequency: _____

¹ The information sought relates only to the condition for which the employee is taking family medical leave.

² "Incapacity," for the purposes of family medical leave, is defined to mean inability to work, attend school or perform other regular daily activities due to the serious health condition, treatment thereof, or recovery therefrom.

6. a. If the patient will be absent from work or other daily activities because of treatment on an intermittent or part-time basis, also provide:

Estimate of probable number of treatments: _____

Interval between treatments: _____

Actual dates of treatments: _____

Length of recovery period, if known: _____

- b. If any of these treatments will be provided by **another provider** of health services (e.g., physical therapist), please state the nature of treatments:

- c. If a **regimen of continuing treatment** by the patient is required **under your supervision**, provide a general description of such regimen (e.g., prescription drugs, physical therapy requiring special equipment):

7. a. If medical leave is required for the employee's **absence from work** because of the **employee's own condition** (including absences due to pregnancy or chronic condition), is the employee **unable to perform work of any kind?**

____ Yes ____ No

- b. If able to perform some work, is the employee **unable to perform any one or more of the essential functions of the employee's job** (the employee or the employer should supply you with information about the essential job functions)?

____ Yes ____ No

If yes, please list the essential functions the employee is unable to perform:

ABSENCE FOR FAMILY MEMBER (must be completed by health care provider in addition to previous questions):

8. a. If leave is required to care for employee's family member with a serious health condition, **does the patient require assistance** for:

Basic medical needs ____ Yes ____ No

Personal needs (hygiene, nutrition, safety) ____ Yes ____ No

Transportation ____ Yes ____ No

- b. If no to all listed in 8a, would the employee's presence to provide **psychological comfort** be beneficial to the patient 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:
Probable duration: _____
Probable frequency: _____

Printed Name of Health Care Provider

Date

Signature of Health Care Provider

Date

Address

Telephone Number

**RETURN COMPLETED FORM TO: CITY OF SALEM, BENEFITS MANAGER,
555 LIBERTY ST. SE, SALEM, OR 97301 – 3513
TELEPHONE NUMBER – 503-588-6162 – FAX 503-588-6170**

SERIOUS HEALTH CONDITION DEFINITIONS

“Serious Health Condition” A serious health condition means an illness, injury, impairment, or physical or mental condition that involves one of the following:

1. Hospital Care:

Inpatient care (i.e., an 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. A period of incapacity of more than three consecutive days, including any subsequent treatment or period of incapacity relating to the same condition, involving:
- b. Treatment³ two or more times by a health care provider, by a nurse or physician’s assistant under direct supervision of a health care provider, or by a provider of health care services, such as a physical therapist, under orders of or on referral by a health care provider, or
- c. Treatment by health care provider on at least one occasion which results in a regimen of continuing treatment⁴ under the supervision of the health care provider.

A regimen of continuing treatment includes, as an example, a course of prescription medication 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.

3. Pregnancy: Any period of incapacity due to pregnancy or for prenatal care.

4. Chronic Conditions Requiring Treatments:

A chronic condition which:

- a. Requires **periodic visits** for treatment by a health care provider, or by a nurse or physician’s assistant under direct supervision of a health care provider
- b. Continues over an extended period of time including recurring episodes of a single underlying condition; and
- c. May cause episodic rather than a continuing period of incapacity such as asthma, diabetes, epilepsy, etc.

³ Treatment includes examinations to determine if a serious health condition exists and evaluations of the condition. Treatment does not include routine physical examinations, eye examinations, or dental examinations.

⁴ A regimen of continuing treatment includes, for example, a course of prescription medications (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, and other similar activities that can be initiated without a visit to a health care provider.

5. Permanent/Long-Term Conditions Requiring Supervision:

A period of incapacity which is permanent or long-term due to a condition for which treatment may not be effective. The employee or family member must be under continuing supervision of, but need not be receiving active treatment by a health care provider. Examples would include Alzheimer's, severe stroke, or terminal state of a disease.

6. Multiple Treatments (Non-Chronic Conditions):

Any period of absence to receive **multiple treatments**, including any period of recovery there from, by a health care provider, either for services under orders of, or on referral by, a health care provider, either for **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 days**, the absence of medical intervention or treatment, such as cancer (chemotherapy, radiation, etc.) severe arthritis (physical therapy), kidney disease (dialysis).

7. Imminent Danger of Death:

An illness, disease or condition that in the medical judgment of the treating health care provider poses an imminent danger of death, is terminal in prognosis with reasonable possibility of death in the near future, or requires constant care.

CITY OF SALEM
RELEASE TO RETURN TO WORK

PART 1: TO BE COMPLETED BY EMPLOYEE

Employee's Name: _____ SSN: _____

PART 2: TO BE COMPLETED BY ATTENDING PHYSICIAN OR PRACTITIONER

1. The above named individual was examined on _____
2. I certify that from _____ to _____ the above named individual was unable to perform the physical requirements of his/her work.

IF PATIENT IS NOT TOTALLY RELEASED TO FULL DUTY AS OF THIS DATE, PLEASE COMPLETE THE FOLLOWING INFORMATION INDICATING ANY LIMITATIONS:

- Number of hours per day patient is able to work _____
- Number of hours per week patient is able to work _____

LIMITATIONS:

- | | |
|--|---|
| <input type="checkbox"/> Bending – Limits _____ | <input type="checkbox"/> Lifting – Limits _____ |
| <input type="checkbox"/> Walking – Limits _____ | <input type="checkbox"/> Sitting – Limits _____ |
| <input type="checkbox"/> Standing – Limits _____ | <input type="checkbox"/> Other*- _____ |

*Please explain _____

3. Date patient is able to return to work full time with **NO** limitations _____
4. Additional Comments _____

PART 3: PHYSICIAN'S/PRACTITIONER'S CERTIFICATION

Physician's/Practitioner's Printed Name: _____

Address and Telephone Number: _____

Physician's/Practitioner's Signature: _____ Date: _____

Type of Practice (Field of Specialization, if any) _____

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