**City of McMinnville**

230 NE 2nd Street

McMinnville, OR 97128

**Family Medical Leave/Oregon Family Leave Request Form**

**First Name Middle Initial Last Name**

**Instructions to employee:** Please use this form when you are requesting consecutive use of Federal Family Leave (FMLA) and Oregon Family Leave (OFLA).

**Please check the appropriate box below:**

* Original Request
* Revision to Previous Request
* Cancellation of a Previous Request
* FMLA and/or OFLA Previously Approved for Same Leave Reason

**Have you taken FMLA/OFLA leave in the current calendar year? \_\_\_ Yes \_\_\_\_No**

**Leave Type Requested (please check all that apply) and Requested Dates:**

\_\_\_\_\_ No work From: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ To: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_ Intermittent Leave From: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ To: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Hours per day requested: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Days per week requested: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_ Reduced Schedule From: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ To: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Hours per day requested: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Days per week requested: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_ Dates are unknown

Comments (optional):

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |

**I request that my leave be charged as follows**

*(Please indicate the number of hours of leave requested)*

**\_\_\_\_\_ Vacation**

**\_\_\_\_\_ Sick Leave**

**\_\_\_\_\_ Floating Holiday Leave**

**\_\_\_\_\_ Management Leave**

**\_\_\_\_\_ Comp Time**

**\_\_\_\_\_ Leave Without Pay**

**\_\_\_\_\_ Other Please specify type of other leave: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**FMLA and OFLA LEAVE: Reason for requested Leave (please check all that apply)**

\_\_\_\_\_ Care for my own serious health condition

\_\_\_\_\_ Care for a newborn child, or newly placed adopted or foster child

\_\_\_\_\_ Care for a sick child needing home care, not a serious health condition

\_\_\_\_\_ Care for family member with a serious health condition:

* + Child (Biological or Adopted)
	+ Child (Dependent Adult Child who is substantially limited by a mental or physical disability)
	+ Child (Domestic Partner’s Child)
	+ Child (Foster Child)
	+ Child (In-local-parentis)
	+ Child (Step-child)
	+ Domestic Partner (Same Gender)
	+ Domestic Partner’s (Same Gender) Child

\_\_\_\_\_ Parental Bonding Leave

\_\_\_\_\_ OFLA Bereavement Leave

\_\_\_\_\_ OFLA Military Family Leave

\_\_\_\_\_ FMLA Military Caregiver Leave

\_\_\_\_ FMLA Military Qualifying Exigency Leave

I understand that I may be required to provide complete and sufficient certification to support my request, for my employer to determine whether my absence qualifies as FMLA and/or OFLA leave.

I acknowledge that I have been given the opportunity to ask questions about my employer’s FMLA and OFLA policies.

I acknowledge that I have read and I understand my employer’s FMLA and OFLA policies.

Print Name Signature Date