



City of Eugene - Family & Medical Leave Information Form

• Send original to • Employee Resource Center • 940 Willamette, Suite 200 • Eugene OR 97401 • Fax: 541-650-3032

EMPLOYEE INFORMATION

Employee's Name: _____ Phone: _____ Employee ID: _____

Supervisor's Name: _____ Phone: _____ Department/Division: _____

Date of Hire (Month & Year): _____ Timekeeper's Name: _____

ANTICIPATED LEAVE DATES AND TYPE OF LEAVE REQUIRED (best estimate)

*Start Date: _____ End Date: _____ (or Check if End Date Unknown)

*(For the birth or placement of a child, enter estimated due date)

<input type="checkbox"/> Consecutive Days (one solid block of time)	<input type="checkbox"/> Intermittent Leave (periodic days off)	<input type="checkbox"/> On a reduced schedule
FROM date _____ TO date _____	____ Days or ____ Hours per <input type="checkbox"/> week or <input type="checkbox"/> month	FROM date _____ TO date _____

REASON FOR LEAVE

Emergency Expanded Family and Medical Leave (to care for your child whose school or place of care is closed, or childcare provider is unavailable, due to COVID-19 related reasons. **Please also complete page 2 of this form.**)

Employee's Serious Health Condition

- Did you file a Workers' Compensation Claim in relation to this illness or injury? - Yes - No

Please refer to the [Family & Medical Leave Guide](#) for more information on Family & Medical Leave for Workers' Compensation claims.

Care of Family Member with Serious Health Condition

▶ Family member's name/relationship to employee: _____

▶ Reason for leave/what care will you provide? _____

▶ If family member is a child, is child under age 18 or mentally or physically disabled? - Yes - No

*Please refer to the [Family & Medical Leave Guide](#) for a list of all FMLA and OFLA qualifying family members.

Pregnancy (any period of disability due to pregnancy, absences for prenatal care, or recovery from childbirth)

Birth of a Child/Adoption or Placement for Adoption of a Child (Parental Leave):

- Is leave requested on an intermittent basis? No Yes (Parental Leave form is required of all EPD and Fire employees)

Servicemember Family Leave (to care for a member of the armed forces who is undergoing medical treatment, recuperation, or therapy for a serious illness or injury that was incurred in the course of active duty)

Qualifying Exigency Leave (OMFLA) (leave in relation to a spouse, son, daughter, or parent on active duty or has been notified of an impending call or order to active duty, in support of a contingency operation for the National Guard or Reserves only)

Leave for Victims of Domestic Violence, Sexual Assault or Stalking (Leave for the victim or the parent or guardian of a victim who is a minor child)

OFLA Non-serious Sick Child Leave (an illness or injury that requires home care but is not a serious health condition)

OFLA Bereavement Leave (to deal with the death of a family member): **Relationship to employee:** _____

SERIOUS HEALTH CONDITION INFORMATION (only complete this section if leave needed due to a serious health condition)

(REQUIRED) Name of the Medical Condition: _____

On the back side of this sheet is a description of various "serious health conditions" categories that will qualify under the Family & Medical Leave Acts. Please check the category(s) that apply to your situation:

<input type="checkbox"/> Hospital Care/Inpatient	<input type="checkbox"/> Absence Plus Treatment	<input type="checkbox"/> Other: _____ _____ _____
<input type="checkbox"/> Pregnancy/Prenatal Care	<input type="checkbox"/> Chronic Condition Requiring Treatment	
<input type="checkbox"/> Perm./Long Term Cond. Requiring Supervision	<input type="checkbox"/>	

FORM COMPLETED BY:

Name: _____ Date: _____

TO BE COMPLETED BY EMPLOYEE RESOURCE CENTER

Date received by Benefits Program: _____ • DOH: • Hrs/Wk: • Total Reg. Hrs. Worked in last 12 Months: _____

Eligible Family Member: Yes No N/A • FMLA/OFLA Coded Last 12 Months: _____ • Eligible for: FMLA/OFLA OFLA ONLY! FMLA ONLY!

Medical Certification Due: _____ Provisional Sent: _____ Final Approval Sent: _____ Denial Sent: _____

Complete the information below only if requesting leave to care for your child whose school/childcare provider is closed/unavailable due to a COVID-19 related reason.

The Expanded **Family and Medical Leave Act** (EFMLA) and Expanded **Oregon Family Leave Act** (EOFLA) allows protected time off work if you are required to care for your own child under age 18, or age 18 or older who is disabled and incapable of self-care, when the child's school/childcare has been closed or is unavailable due to a COVID-19 related reason. The definition of your own child includes a biological, adopted, foster or stepchild; a legal ward; or someone to whom the employee stands *in loco parentis*.

Additional information regarding pay and eligibility for EFMLA/EOFLA is available in the [EFMLA/EOFLA Policy](#) and the [EFMLA FAQs](#).

- I affirm I am unable to work or telework because I need to care for my child whose school or place of care is closed, or whose childcare provider is unavailable, due to COVID-19 related reasons.*
- I have had a conversation with my supervisor to explore flexible work options, and there is still a need for me to take leave under EFMLA*
- If I am requesting intermittent leave, my supervisor has approved my intermittent leave schedule*
- I affirm that no other suitable person is available to care for my children during the period of requested leave, and that no other person will be providing care for my children during my approved EFMLA leave.*
I understand I do not qualify for this leave if an emergency childcare provider is available to care for my child.
- If my child is older than age 14, I affirm that special circumstances exist requiring me to provide care for them during daylight hours*

Names and ages of my children up to age 18 (or older if disabled and incapable of self-care) for whom I need to provide care:

Name of each unavailable school or childcare provider:

I intend to use Emergency Paid Sick Leave (EPSL) for the first two weeks of leave eligible under EFMLA Yes (Please also complete the [EPSL Request form](#)) No

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, within 30 days of the first day of incapacity, unless extenuating circumstances exist, 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 and with the first (or only) in-person treatment visit taking place within seven days of the first day of incapacity, **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/Prenatal care –

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 (defined as at least twice a year) 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 condition 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.

Definition of Treatment: Includes examinations to determine if a serious health condition exists and for evaluations of the condition. The definition does not include routine physical examinations, eye examinations or dental examinations.