

LEAVE REQUEST**DALLAS SCHOOL DISTRICT #2**

Dallas, Oregon 97338

Employee Name: _____ Date: _____

LEAVE REQUESTED

Date(s) _____	Hours _____	Personal/Misc.	Vacation	Med/Sick	Unpaid	* Professional (explain) _____
						In District Out of District _____ Funding Source
Date(s) _____	Hours _____	Personal/Misc.	Vacation	Med/Sick	Unpaid	* Professional (explain) _____
						In District Out of District _____ Funding Source
Date(s) _____	Hours _____	Personal/Misc.	Vacation	Med/Sick	Unpaid	* Professional (explain) _____
						In District Out of District _____ Funding Source

Unpaid leave is only available as described in the collective bargaining agreement for your position***Please note professional leave as in or out of district and any special funding source.**

Under federal and state law, an employee requesting FMLA and/or OFLA leave shall provide at least **30 DAYS NOTICE** prior to the leave date if the leave is foreseeable. The notice shall be written and include the anticipated start, duration and reasons for the requested leave. 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.

EMPLOYEE: COMPLETE THIS SECTION ONLY IF REQUESTING OFLA/FMLA LEAVE.
OTHERWISE, YOU MAY PROCEED TO SIGNATURE LINE AT BOTTOM.

1) Have you worked for the district at least 180 days and an average of 25 hours per week?

Yes *You qualify for OFLA/FMLA Leave. Answer questions 2-4 below.*
No *You do not qualify for OFLA/FMLA Leave. Proceed to signature line at bottom of form.*

2) Please check all that apply:

Your serious health condition (certification may be required)
Family members with serious health condition (certification may be required)
Child requiring home care
Pregnancy (includes prenatal care, childbirth and recovery)
Care for a newborn child
Placement/adoption of child or adult dependent
Parent-in-law with condition that poses imminent danger of death, is terminal or requires constant care
Qualifying Exigency for Military Family leave

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

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

4) 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 the district to ask for additional information to determine whether the leave is OFLA/FMLA qualifying. Any disclosure of medical information will be kept in a confidential file and will be used only to determine eligibility for OFLA/FMLA and to track leave.

For Office Use Only

Date request received by District Office: _____

Leave Approved: Yes No If no, state reason: _____

Provisional Leave Designation (Pending additional information or medical certification) OFLA FMLA BOTH

Date Employee Notified of approval/denial _____ Date copies sent to: Payroll/Leave _____

Employee Signature: _____**Supervisor's Signature:** _____ **Date:** _____