Washington County Consolidated Communications Agency
WCCCA

Family Medical Leave Act (FMLA) and
Oregon Family Leave Act (OFLA)

Forms Packet

Please Read This Statement

This packet contains medical certification forms used to request Family and Medical leave under FMLA and/or OFLA. In all cases, applicable state and federal laws, rules, policies and collective bargaining agreements govern the employee's and the agency's rights and obligations; not this document.

FMLA and OFLA are not optional. The law requires the agency to provide these entitlements.

Federal and state law prohibit retaliation against an employee with respect to hiring or any other term or condition of employment because the employee asked about, requested or used Family and Medical Leave.

Why am I receiving this **Forms Packet**?

- It was requested by you, or
- HR was notified that you had an absence that may qualify under FMLA and/or OFLA

What happens next?

- Have the medical provider complete either the "Employee - Serious Health Condition" form or the "Family Member – Serious Health Condition" form, depending on the type of leave you are requesting. Both forms are included in this **Forms Packet**.
- Your medical provider can return the completed form to you or they may fax it to Human Resources on the confidential fax at 503-531-1306.
- Human Resources will send you a "Designation Form" notifying you if your leave is approved or not under FMLA and/or OFLA. If additional information is needed to make a designation, you will be notified.

Jennifer Kilcoin
Human Resources Generalist
503-690-4911, ext. 206
jkilcoin@wccca.com

Human Resources Confidential Fax
503-531-1306

9-1-1 WCCCA POLICE · FIRE · MEDICAL	**Washington County Consolidated Communications Agency** Medical Certification of Health Care Provider Family and Medical Leave Act (FMLA and OFLA).

EMPLOYEE - SERIOUS HEALTH CONDITION

Employee's Name:

When completed send to: Confidential fax: **503-531-1306**; Email: jkilcoin@wccca.com; Mail: Jennifer Kilcoin-HR, 17911 NW Evergreen Pkwy, Beaverton, OR 97006

To receive FMLA/OFLA protection for leave, WCCCA must receive **timely, complete, and sufficient** medical certification to support a request for FMLA/OFLA leave. You must return this form within 15 calendar days. This information is required to obtain or retain the benefit of FMLA/OFLA protections. Failure to provide a complete and sufficient medical certification may result in a denial of the FMLA/OFLA request. **THIS FORM IS TO BE COMPLETED BY THE HEALTH CARE PROVIDER.**

Employers must generally maintain records and documents relating to medical certifications, re-certifications, or medical histories of employees created for FMLA/OFLA purposes as confidential medical records in separate files/records from the usual personnel files and in accordance with state and federal law.

INSTRUCTIONS TO THE HEALTH CARE PROVIDER: Your patient has requested leave under FMLA/OFLA. Answer, fully and completely, all applicable parts of this form. Your answers should be your best estimate based upon your medical knowledge, experience and examination of the patient. Be as specific as you can: **Terms such as "lifetime," "unknown," or "indeterminate" may not be sufficient to determine FMLA/OFLA coverage.** ***Please be sure to sign the form on the last page.***

Print Provider's Name and License Held: _____

Business Address: _____

Type of Practice/Medical Specialty: _____ Phone: _____

Employee's Job Title: _____ Regular Work Schedule: _____

Employee's Essential Job Functions: _____

_____

Check if Job Description is Attached: _____

MEDICAL FACTS

1. State approximate date condition commenced: _____
2. Probable duration of condition from the date condition commenced: _____
3. Was or will the patient be admitted for an overnight stay in a hospital, hospice, or residential medical care facility? □ No □ Yes **If yes**, date(s) of admission: _____
4. Date(s) you treated the patient for this condition: _____
   (Dates of treatment for this condition in the last 12 months)

5. Has medication, other than over-the-counter medication, been prescribed? □ No □ Yes

6. Are treatments schedule at least twice per year due to the condition? □ No □ Yes

7. Was the patient referred to other health care provider(s) for evaluation or treatment, (e.g. physical therapists)? □ No □ Yes **If yes**, state the nature of such treatments and expected duration of treatment:

_____

_____

_____

8. Describe any relevant medical facts, related to the condition for which the patient needs care. Such medical facts may include symptoms, diagnosis, or any regimen of continuing treatment such as the use of specialized equipment (if pregnancy, provided estimated due date):

_____

_____

9. If the employer does not provide a list of the employee's essential functions or a job description, answer these questions based upon the employee's own description of his/her job functions. Is the employee unable to perform any of his/her job functions with the condition? □ No □ Yes **If yes**, identify the job functions the employee is unable to perform: _____

_____

_____

AMOUNT OF LEAVE NEEDED

10. Will the employee be incapacitated for a **single continuous period** of time due to his/her medical condition, including any time for treatment and recovery? □ No □ Yes

    If yes, estimate the beginning and ending dates for the period of incapacity:

    From:_____ through _____
    (date) (date)

11. Will the employee need to work **part-time** or a reduced schedule due to the employee's medical condition? □ No □ Yes

    If yes, estimate the part-time or reduced work schedule the employee is able to work:

    Hours per day:_____ and days per week:_____ From:_____ through _____
    (date) (date)

Confidential fax: **503-531-1306**; Email: jkilcoin@wccca.com; Mail: Jennifer Kilcoin-HR, 17911 NW Evergreen Pkwy, Beaverton, OR 97006

12. Will the employee need to attend follow-up **treatment appointments that are medically necessary** due to the employee's medical condition? □ No □ Yes

If yes, estimate treatment(s) scheduled if any, including the dates of any scheduled appointment and time required for each appointment, including any recovery period:

Patient has scheduled appointments on _____ and/or

Patient may have appointments from:_____ through _____
(date) (date)

Frequency:_____ appointments per _____ week(s) **OR** _____month(s), lasting _____ hours.

13. Will the condition cause episodic **flare-ups***, periodically preventing the employee from performing his/her job functions? □ No □ Yes

If yes, explain why it is medically necessary for the employee to be absent from work during the flare-ups: estimate treatment(s) schedule:

_____

_____

(*Flare-ups are **not** appointments or continuous leave)

Based on the patient's medical history and your knowledge of the medical condition, estimate the frequency of the flare-ups and the duration of related incapacity that the patient may have over the next 6 months:
(e.g. 1 episode every 3 months lasting 1-2 days from January 1 through July 30):

Patient may have flare-ups from:_____ through _____
(date) (date)

Frequency:_____ episode(s) per _____ week(s) **OR** _____month(s)

Duration: _____ hours or _____ day(s) per episode

Note: an estimate must be provided. Using "unknown" or "indeterminate" will not provide sufficient information to be able to grant leave for flare-ups. If condition changes, treating providers may update their estimated frequency and duration.

ADDITIONAL INFORMATION

_____

_____

_____ _____
Signature of Health Care Provider Date

"The Genetic Information Nondiscrimination Act of 2008 (GINA) prohibits employers and other entities covered by GINA Title II from requesting or requiring genetic information of employees or their family members. In order to comply with this law, we are asking that you not provide any genetic information when responding to this request for medical information. 'Genetic information,' as defined by GINA, includes an individual's family medical history, the results of an individual's or family member's genetic test, the fact that an individual or an individual's family member sought or received genetic services, and genetic information of a fetus carried by an individual or an individual's family member or an embryo lawfully held by an individual or an individual's family member receiving reproductive services."

Confidential fax: **503-531-1306**; Email: jkilcoin@wccca.com; Mail: Jennifer Kilcoin-HR, 17911 NW Evergreen Pkwy, Beaverton, OR 97006

Washington County Consolidated Communications Agency

Medical Certification of Health Care Provider
Family and Medical Leave Act
(FMLA and OFLA).

FAMILY MEMBER - SERIOUS HEALTH CONDITION

Employee's Name:	Your Relationship To the Patient:
Patient's Name:	Patient's Date of Birth:

By signing, I acknowledge that any leave I use will be to care for the family member certified on this form.

Employee Signature _____ Date _____

When completed send to: Confidential fax: **503-531-1306**; Email: jkilcoin@wccca.com; Mail: Jennifer Kilcoin-HR, 17911 NW Evergreen Pkwy, Beaverton, OR 97006

To receive FMLA/OFLA protection for leave, WCCCA must receive timely, complete, and sufficient medical certification to support a request for FMLA/OFLA leave. You must return this form within 15 calendar days. This information is required to obtain or retain the benefit of FMLA/OFLA protections. Failure to provide a complete and sufficient medical certification may result in a denial of the FMLA/OFLA request. **THIS FORM IS TO BE COMPLETED BY THE HEALTH CARE PROVIDER.**

Employers must generally maintain records and documents relating to medical certifications, re-certifications, or medical histories of employees created for FMLA/OFLA purposes as confidential medical records in separate files/records from the usual personnel files and in accordance with state and federal law.

INSTRUCTIONS TO THE HEALTH CARE PROVIDER: The family member of your patient has requested leave under FMLA/OFLA. Answer, fully and completely, all applicable parts of this form. Your answers should be your best estimate based upon your medical knowledge, experience and examination of the patient. Be as specific as you can: **Terms such as "lifetime," "unknown," or "indeterminate" may not be sufficient to determine FMLA/OFLA coverage.** ***Please be sure to sign the form on the last page.***

Print Provider's Name and License Held: _____

Business Address: _____

Type of Practice/Medical Specialty: _____ Phone: _____

MEDICAL FACTS

1. State approximate date condition commenced: _____
2. Probable duration of condition from the date condition commenced: _____
3. Was or will the patient be admitted for an overnight stay in a hospital, hospice, or residential medical care facility? □ No □ Yes **If yes**, date(s) of admission: _____
4. Date(s) you treated the patient for this condition: _____
   (Dates of treatment for this condition in the last 12 months)

5. Has medication, other than over-the-counter medication, been prescribed? □ No □ Yes

6. Are treatments scheduled at least twice per year due to the condition? □ No □ Yes

7. Was the patient referred to other health care provider(s) for evaluation or treatment, (e.g. physical therapists)? □ No □ Yes **If yes**, state the nature of such treatments and expected duration of treatment:

_____

_____

8. Describe any relevant medical facts, related to the condition for which the patient needs care. Such medical facts may include symptoms, diagnosis, or any regimen of continuing treatment such as the use of specialized equipment (if pregnancy, provided estimated due date):

_____

_____

MEDICAL CARE NEEDED (Childcare is not a qualifying condition)
Care for your patient, which will be provided by the employee seeking leave, may include the following:

- medical care
- hygienic care
- nutritional care
- safety
- transportation
- physical care
- psychological care

9. Will the patient be incapacitated, requiring continuous and/or intermittent care? □ No □ Yes

If yes for Continuous Care: Estimate beginning and ending dates From: _____ through _____
(date) (date)

If yes for Intermittent Care: Estimate the number of hours per day care is needed on an intermittent basis, not including time or appointment, continuous leave or flare-ups:

Hours per day:_____ and days per week:_____ From:_____ through _____
(date) (date)

Provide an explanation of the care needed by the patient during either continuous or intermittent care:

_____

_____

(Do **not** provide information for scheduled appointment(s).)

10. Will the patient **require assistance** for follow up treatments, including recovery time? □ No □ Yes

If yes, estimate treatment(s) schedule:
Patient has scheduled appointments on _____ and/or

Patient may have appointments from:_____ through _____
(date) (date)

Frequency:_____ appointments per _____ week(s) **OR** _____month(s), lasting _____ hours.

Confidential fax: **503-531-1306**; Email: jkilcoin@wccca.com; Mail: Jennifer Kilcoin-HR, 17911 NW Evergreen Pkwy, Beaverton, OR 97006

11. Will the condition cause episodic **flare-ups***, periodically preventing the patient from participating in normal daily activities and where care from the family member(s) is required during the flare-ups? □ No □ Yes

If yes, based upon the patient's medical history and your knowledge of the medical condition, estimate the frequency of the flare-ups and the duration of related incapacity that the patient may have over the next six month (e.g. 1 episode every 3 months lasting 1-2 days from January 1 through July 30):

Patient may have flare-ups from:_____ through _____
(date) (date)

Frequency:_____ episode(s) per _____ week(s) **OR** _____month(s)

Duration: _____ hours or _____ day(s) per episode

Note: an estimate must be provided. Using "unknown" or "indeterminate" will not provide sufficient information to be able to grant leave for flare-ups. If condition changes, treating providers may update their estimate frequency and duration.

Explain the **care needed** by the patient during flare-ups (see bulleted points above):

_____

_____

(*Flare-ups are **not** appointments or continuous leave)

ADDITIONAL INFORMATION

_____

_____

_____

_____ _____
Signature of Health Care Provider Date

"The Genetic Information Nondiscrimination Act of 2008 (GINA) prohibits employers and other entities covered by GINA Title II from requesting or requiring genetic information of employees or their family members. In order to comply with this law, we are asking that you not provide any genetic information when responding to this request for medical information. 'Genetic information,' as defined by GINA, includes an individual's family medical history, the results of an individual's or family member's genetic test, the fact that an individual or an individual's family member sought or received genetic services, and genetic information of a fetus carried by an individual or an individual's family member or an embryo lawfully held by an individual or an individual's family member receiving reproductive services."

Confidential fax: **503-531-1306**; Email: jkilcoin@wccca.com; Mail: Jennifer Kilcoin-HR, 17911 NW Evergreen Pkwy, Beaverton, OR 97006

EMPLOYEE RIGHTS AND RESPONSIBILITIES
UNDER THE FAMILY AND MEDICAL LEAVE ACT

Basic Leave Entitlement
FMLA requires covered employers to provide up to 12 weeks of unpaid, job-protected leave to eligible employees for the following reasons:

- for incapacity due to pregnancy, prenatal medical care or child birth;
- to care for the employee's child after birth, or placement for adoption or foster care;
- to care for the employee's spouse, son, daughter or parent, who has a serious health condition; or
- for a serious health condition that makes the employee unable to perform the employee's job.

Military Family Leave Entitlements
Eligible employees whose spouse, son, daughter or parent is on covered active duty or call to covered active duty status may use their 12-week leave entitlement to address certain qualifying exigencies. Qualifying exigencies may include attending certain military events, arranging for alternative childcare, addressing certain financial and legal arrangements, attending certain counseling sessions, and attending post-deployment reintegration briefings.

FMLA also includes a special leave entitlement that permits eligible employees to take up to 26 weeks of leave to care for a covered servicemember during a single 12-month period. A covered servicemember is: (1) a current member of the Armed Forces, including a member of the National Guard or Reserves, who is undergoing medical treatment, recuperation or therapy, is otherwise in outpatient status, or is otherwise on the temporary disability retired list, for a serious injury or illness*; or (2) a veteran who was discharged or released under conditions other than dishonorable at any time during the five-year period prior to the first date the eligible employee takes FMLA leave to care for the covered veteran, and who is undergoing medical treatment, recuperation, or therapy for a serious injury or illness.*

***The FMLA definitions of "serious injury or illness" for current servicemembers and veterans are distinct from the FMLA definition of "serious health condition".**

Benefits and Protections
During FMLA leave, the employer must maintain the employee's health coverage under any "group health plan" on the same terms as if the employee had continued to work. Upon return from FMLA leave, most employees must be restored to their original or equivalent positions with equivalent pay, benefits, and other employment terms.

Use of FMLA leave cannot result in the loss of any employment benefit that accrued prior to the start of an employee's leave.

Eligibility Requirements
Employees are eligible if they have worked for a covered employer for at least 12 months, have 1,250 hours of service in the previous 12 months*, and if at least 50 employees are employed by the employer within 75 miles.

***Special hours of service eligibility requirements apply to airline flight crew employees.**

Definition of Serious Health Condition
A serious health condition is an illness, injury, impairment, or physical or mental condition that involves either an overnight stay in a medical care facility, or continuing treatment by a health care provider for a condition that either prevents the employee from performing the functions of the employee's job, or prevents the qualified family member from participating in school or other daily activities.

Subject to certain conditions, the continuing treatment requirement may be met by a period of incapacity of more than 3 consecutive calendar days combined with at least two visits to a health care provider or one visit and a regimen of continuing treatment, or incapacity due to pregnancy, or incapacity due to a chronic condition. Other conditions may meet the definition of continuing treatment.

Use of Leave
An employee does not need to use this leave entitlement in one block. Leave can be taken intermittently or on a reduced leave schedule when medically necessary. Employees must make reasonable efforts to schedule leave for planned medical treatment so as not to unduly disrupt the employer's operations. Leave due to qualifying exigencies may also be taken on an intermittent basis.

Substitution of Paid Leave for Unpaid Leave
Employees may choose or employers may require use of accrued paid leave while taking FMLA leave. In order to use paid leave for FMLA leave, employees must comply with the employer's normal paid leave policies.

Employee Responsibilities
Employees must provide 30 days advance notice of the need to take FMLA leave when the need is foreseeable. When 30 days notice is not possible, the employee must provide notice as soon as practicable and generally must comply with an employer's normal call-in procedures.

Employees must provide sufficient information for the employer to determine if the leave may qualify for FMLA protection and the anticipated timing and duration of the leave. Sufficient information may include that the employee is unable to perform job functions, the family member is unable to perform daily activities, the need for hospitalization or continuing treatment by a health care provider, or circumstances supporting the need for military family leave. Employees also must inform the employer if the requested leave is for a reason for which FMLA leave was previously taken or certified. Employees also may be required to provide a certification and periodic recertification supporting the need for leave.

Employer Responsibilities
Covered employers must inform employees requesting leave whether they are eligible under FMLA. If they are, the notice must specify any additional information required as well as the employees' rights and responsibilities. If they are not eligible, the employer must provide a reason for the ineligibility.

Covered employers must inform employees if leave will be designated as FMLA-protected and the amount of leave counted against the employee's leave entitlement. If the employer determines that the leave is not FMLA-protected, the employer must notify the employee.

Unlawful Acts by Employers
FMLA makes it unlawful for any employer to:

- interfere with, restrain, or deny the exercise of any right provided under FMLA; and
- discharge or discriminate against any person for opposing any practice made unlawful by FMLA or for involvement in any proceeding under or relating to FMLA.

Enforcement
An employee may file a complaint with the U.S. Department of Labor or may bring a private lawsuit against an employer.

FMLA does not affect any Federal or State law prohibiting discrimination, or supersede any State or local law or collective bargaining agreement which provides greater family or medical leave rights.

FMLA section 109 (29 U.S.C. § 2619) requires FMLA covered employers to post the text of this notice. Regulation 29 C.F.R. § 825.300(a) may require additional disclosures.

For additional information:
1-866-4US-WAGE (1-866-487-9243) TTY: 1-877-889-5627
WWW.WAGEHOUR.DOL.GOV

U.S. Department of Labor | Wage and Hour Division

WHD Publication 1420 · Revised February 2013

BUREAU OF LABOR AND INDUSTRIES

Brad Avakian, Commissioner

Oregon FAMILY LEAVE ACT

NOTICE TO EMPLOYERS AND EMPLOYEES

The Oregon Family Leave Act (OFLA) requires employers of 25 or more employees to provide eligible workers with protected leave to care for themselves or family members in cases of death, illness, injury, childbirth, adoption and foster placement.

ORS 659A.150 to 659A.186

When can an Employee take Family Leave?

Employees can take family leave for the following reasons:

⇒ **Parental Leave** during the year following the birth of a child or adoption or foster placement of a child under 18, or a child 18 or older if incapable of self-care because of a mental or physical disability. Parental leave includes leave to effectuate the legal process required for foster placement or adoption.

⇒ **Serious health condition leave** for the employee's own serious health condition, or to care for a spouse, parent, child, parent-in-law, grandparent, grandchild or same gender domestic partner with a serious health condition. NOTE: Does not include an employee unable to work due to a compensable Workers Compensation injury.

⇒ **Pregnancy disability leave** (a form of serious health condition leave) taken by a female employee for an incapacity related to pregnancy or childbirth, occurring before or after the birth of the child, or for prenatal care.

⇒ **Sick child leave** taken to care for an employee's child with an illness or injury that requires home care but is not a serious health condition.

⇒ **Bereavement leave** to deal with the death of a family member.

⇒ **Oregon Military Family Leave** is taken by the spouse or same gender domestic partner of a service member who has been called to active duty or notified of an impending call to active duty or is on leave from active duty during a period of military conflict.

Who is Eligible?

To be eligible for leave, workers must be employed for the 180 day calendar period immediately preceding the leave and have worked at least an average of 25 hours per week during the 180-day period.

Exception 1: For parental leave, workers are eligible after being employed for 180 calendar days, without regard to the number of hours worked.

Exception 2: For Oregon Military Family Leave, workers are eligible if they have worked at least an average of 20 hours per week, without regard to the duration of employment.

How much Leave can an Employee take?

⇒ Employees are generally entitled to a maximum of 12 weeks of family leave within the employer's 12-month leave year.

⇒ A woman using pregnancy disability leave is entitled to 12 additional weeks of leave in the same leave year for any qualifying OFLA purpose.

⇒ A man or woman using a full 12 weeks of parental leave is entitled to take up to 12 additional weeks for the purpose of sick child leave.

⇒ Employees are entitled to 2 weeks of bereavement leave to be taken within 60 days of the notice of the death of a covered family member.

⇒ A spouse or same gender domestic partner of a service member is entitled to a total of 14 days of leave per deployment after the military spouse has been notified of an impending call or order to active duty and before deployment and when the military spouse is on leave from deployment.

What Notice is Required?

Employees may be required to give 30 days notice in advance of leave, unless the leave is taken for an emergency. Employers may require that notice is given in writing. In an emergency, employees must give verbal notice within 24 hours of starting a leave.

Is Family Leave Paid or Unpaid?

Although Family Leave is unpaid, employees are entitled to use any accrued paid vacation, sick or other paid leave.

How is an Employee's job Protected?

Employers must return employees to their former jobs or to equivalent jobs if the former position no longer exists. However, employees on OFLA leave are still subject to nondiscriminatory employment actions such as layoff or discipline that would have been taken without regard to the employee's leave.

FOR ADDITIONAL INFORMATION:

Employer Assistance . . . 971-673-0824
Portland 971-673-0761
Eugene 541-686-7623
Salem 503-378-3292

www.oregon.gov/BOLI

BOLI
Civil Rights Division
800 NE Oregon, #1045
Portland, OR 97232

Employees who have been denied available leave, disciplined or retaliated against for requesting or taking leave, or have been denied reinstatement to the same or equivalent position when they returned from leave, may file a complaint with BOLI's Civil Rights Division.

This is a summary of laws relating to Oregon Family Leave Act.
It is not a complete text of the law.

January 2015

THIS INFORMATION MUST BE POSTED IN A CONSPICUOUS LOCATION