FAMILY MEDICAL LEAVE ACT (FMLA) AND OREGON FAMILY LEAVE ACT (OFLA)

Employee Information and Instructions

Please submit this application to Human Resources at least 30 days prior to the first day your leave will commence. If leave is to begin in less than 30 days, and/or, if the leave is unforeseeable, please submit this form as soon as possible, under the circumstances.

Qualifying Reasons for Protected Leave

- ○ FMLA/OFLA Serious Health Conditions (employee or covered family member)
- ○ FMLA/OLFA Pregnancy
- ○ FMLA/OLFA Parental Leave
- ○ OFLA Sick Child Leave (non-serious health condition)
- ○ OFLA Bereavement Leave (up to 10 total days)
- ○ Oregon Military Leave (OMFLA)
- ○ FMLA Military Caregiver
- ◉ FMLA Qualifying Exigency Leave

- Leave may be processed according to the County's FMLA/OFLA policies or union contract.
- After all accrued leave is exhausted, if eligible, an employee may be placed on unpaid leave.

Length of Leave

Usually, FMLA/OFLA leave is available for up to 12 weeks per family leave year. In some circumstances, an employee may be eligible for more than 12 weeks in the same family leave year.

Employee Eligibility

OFLA	FMLA
Have worked for a period of 180 calendar days immediately preceding the date leave begins, AND worked 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, eligible workers must work for an employer an average of at least 20 hours per week without regard to the number of days worked	Have worked for a total of at least 12 months AND worked at least 1250 hours during the 12-month period preceding the leave.

Once completed please submit to hr@klamathcounty.org.

Items Employee Needs to Return to Human Resources

BEFORE LEAVE

1. Complete application for FMLA/OFLA Leave.
2. Have your medical provider complete the Medical Certification Form if required. The certification can be faxed directly to HR (541) 883-4270 from the medical provider's office, or the employee may provide it directly to HR. Medical Certifications must be provided within 15 days from the date of application for serious health condition, if the leave is foreseeable.

AFTER LEAVE

Fax work release to HR, and then forward the original through confidential inner-office mail, or deliver the work release directly to HR.

3. Once employee returns to work, if there are restrictions or modifications provide modified work release. The use of a boot/brace/cast/sling does not constitute a full release.
4. Once employee has been approved to return to work with no restrictions or modifications provide new work release.

Medical Certification Form

SECTION I: For Completion by the EMPLOYER

Employer name: Klamath County
Employer contact: Human Resources Department (541) 883-4296
Employer Fax: (541) 883-4270
Employee's job title: _____
Check if job description is attached: ☑ YES ☐ NO

SECTION II: For Completion by the EMPLOYEE

INSTRUCTIONS to the EMPLOYEE: Please complete Section II before giving this form to *patient's (your own or your covered family member's)* health care provider. FMLA/OFLA permits an employer to require that you submit a timely, complete, and sufficient medical certification to support a request for FMLA/OFLA leave due to your own *or your covered family member's* serious health condition. If requested by your employer, your response is required to obtain or retain the benefit of FMLA/OFLA protections. 29 U.S.C. §§ 2613, 2614(c)(3). Failure to provide a complete and sufficient medical certification may result in delay or denial of FMLA / OFLA protection. 29 C.F.R. § 825.313. Your employer must give you at least 15 calendar days to return this form. 29 C.F.R. § 825.305(b), OAR 839-009-0260(4).

Employee's Name: _____

Complete the following for Certification of Family Member's Serious Health Condition:

Patient's Name (*if different from employee*): _____
If patient is a child, date of birth (mm/dd/yyyy): ___/___/_____

Once completed please submit to hr@klamathcounty.org.

Patient's Relationship to Employee:

- ◯ Spouse/Domestic Partner
- ◯ Child
- ◯ Parent
- ◯ Parent-in-law
- ◯ Grandparent
- ◯ Grandparent-in-law

Describe care you will provide to your family member and estimate leave needed to provide care:

SECTION III: For Completion by the HEALTH CARE PROVIDER

INSTRUCTIONS to the HEALTH CARE PROVIDER: Either your patient has requested leave under the FMLA/OFLA ***or*** *the employee listed above has requested leave under the FMLA/OFLA to care for your patient (employee's family member).* Answer, fully and completely, all applicable parts. Several questions seek a response as to the frequency or duration of a condition, treatment, etc. Your answer 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 limit your responses to the condition for which the employee is seeking leave. 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 an individual or family member of the individual, except as specifically allowed by this law. 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 tests, 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 family member receiving assistive reproductive services. If you share more information than we have requested, we may return the form and ask that you re-submit it.

_____

Printed Name of Physician/ Practitioner

_____

Signature of Physician/ Practitioner

_____

Type of Practice/Medical Specialty

_____

Address

_____ _____

Date Signed Phone Number

Once completed please submit to hr@klamathcounty.org.

PART A: MEDICAL FACTS

1) Approximate date condition commenced: _____

a) Probable duration of condition: _____
b) Was the patient admitted for inpatient care in a hospital, hospice, or residential medical care facility? ☐**No**☐ **Yes** If **YES**, dates of admission: _____
c) Date(s) you treated the patient for the condition: _____
d) Was medication, other than over-the-counter medication, prescribed? ☐ **No** ☐ **Yes**
e) Will the patient need to have treatment / visits at least twice per year due to the condition? ☐ **No** ☐ **Yes**
f) Was the patient referred to other health care provider(s) for evaluation or treatment (e.g., physical therapist)? ☐ **No** ☐ **Yes** If **YES**, state the nature of such treatments and expected duration of treatment:

2) If patient is EMPLOYEE *(Use the information provided by the employer in Section I to answer this question).*
If the employer fails to 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.

a) Is the employee unable to perform any of his/her job functions due to the condition?
☐**No** ☐**Yes** If **YES**, identify the job functions the employee is unable to perform:

3) Describe other relevant medical facts, if any, related to the condition for which the employee seeks leave (such medical facts may include symptoms, diagnosis, or any regimen of continuing treatment such as the use of specialized equipment):

PART B: AMOUNT OF CARE NEEDED

When answering these questions, keep in mind that your patient's need for care may include assistance with basic medical, hygienic, nutritional, safety or transportation needs, or the provision of physical or psychological care:

4) Will the patient be incapacitated for a single continuous period of time, including any time for treatment and recovery? ☐ **No** ☐ **Yes** If **YES**, estimate the beginning and end dates for any period of incapacity:

If this certification relates to the employee's seriously ill family member(s), also complete the following:

a) Does the patient require assistance for basic medical or personal needs or safety, or for transportation? ☐ **No** ☐ **Yes**

b) If the patient will need care only intermittently or on a part-time basis, please indicate the probable duration and frequency of this need: _____
Please explain the care needed by the patient: _____

5) Will the patient require follow-up treatments, including any time for recovery? ☐ **No** ☐**Yes**

6) Will it be necessary for the employee to take leave only intermittently or to work on a less than full-time schedule basis because of the condition or treatment? ☐ **No** ☐ **Yes** If **YES**, expected duration:

Frequency (Check One):

- ☐ One (1) to two (2) days per month
- ☐ Two (2) to three (3) days per month
- ☐ Three (3) to four (4) days per month
- ☐ Other -Explain:

7) Will the patient require a regimen of treatment? ☐ **No** ☐ **Yes** If **YES**, describe the nature of the treatments:

Estimated number of treatments: _____
Estimated interval between treatments: _____
Estimated or actual dates of treatments: _____

What is the duration (and any period required for recovery) for a treatment?

Return form to: **Klamath County Human Resources**
305 Main St. #216
Klamath Falls, OR 97601
541.883.4296 - Fax 541.883.4270

RETURN-TO-WORK STATUS

Worker's name: _____ Claim number (if known): _____

Next scheduled appointment date: _____

Is the worker expected to materially improve from medical treatment or the passage of time? ◯ **Yes** ◯ **No**

WORK STATUS *(Select one option)*

◯ **OPTION 1 Released to Regular Work** Status from (date): _____

Released to the ***hours routinely worked and tasks routinely performed in the job held at the time of injury.***

◯ **OPTION 2 Not Released to Work** Status from (date): _____ to: _____

The worker is ***not capable of performing any work activities***.

◯ **OPTION 3 Released to Modified Work** Status from (date): _____ to: _____

Released to work, ***subject to the following work restrictions (note only those that are applicable):***

Total work hours: ____ hours/day

Lift/carry/push/pull restrictions

	One-time	*≤1/3 of workday*	*1/3-2/3 of workday*	*≥2/3 of workday*	*Duration*	
Lift:	____ pounds	____ pounds	____ pounds	____ pounds	____ hrs./day	____ hrs./one time
Carry:	____ pounds	____ pounds	____ pounds	____ pounds	____ hrs./day	____ hrs./one time
Push:	____ pounds	____ pounds	____ pounds	____ pounds	____ hrs./day	____ hrs./one time
Pull:	____ pounds	____ pounds	____ pounds	____ pounds	____ hrs./day	____ hrs./one time

Activity restrictions

Stand:	____ hrs./day	____ hrs./one time	***Twist:***	____ hrs./day	____ hrs./one time	***Crawl:***	____ hrs./day	____ hrs./one time
Walk:	____ hrs./day	____ hrs./one time	***Climb:***	____ hrs./day	____ hrs./one time	***Crouch:***	____ hrs./day	____ hrs./one time
Sit:	____ hrs./day	____ hrs./one time	***Bend:***	____ hrs./day	____ hrs./one time	***Balance:***	____ hrs./day	____ hrs./one time
Drive:	____ hrs./day	____ hrs./one time	***Above-shoulder-reach:***	____ hrs./day	____ hrs./one time	***Below-shoulder-reach:***	____ hrs./day	____ hrs./one time
Kneel:	____ hrs./day	____ hrs./one time						

Hand use restrictions

Fine actions:	____ hrs./day L hand	____ hrs./day R hand
Keyboarding:	____ hrs./day L hand	____ hrs./day R hand
Grasp:	____ hrs./day L hand	____ hrs./day R hand

Foot use restrictions

Raise:	____ hrs./day L foot	____ hrs./day R foot
Push:	____ hrs./day L foot	____ hrs./day R foot

Notes / other restrictions:

Medical provider's signature: _____ Date: _____

Print medical provider's name: _____ Phone no.: _____