EMPLOYEE LEAVE REQUEST

Employee Name: ___________________________ Today’s Date: ______________

Have you worked for UCC for at least 180 days? □ Yes □ No

I request one day or less: Date: ________ Hours: ________

I request more than one day: Beginning date: ________ Return date: ________

Total number of hours taken: __________________________

I request that my leave be charged to:

____ Vacation  ______ Personal Time
____ Unpaid Leave ______ Bereavement
____ Other: __________ ______ Domestic Violence/Assault/Stalking
____ Sick ______ Military (self)
____ Jury Duty ______ Military (family member)

For HR Dept. Use Only:

Leave Designation:
□ OFLA □ FMIA □ Both

Provisional Leave Designation (pending additional information or medical certification.)

□ OFLA □ FMIA □ Both

Date Employee Notified: ____________

If requesting OFLA/FMLA leave, please complete this section. Otherwise, please proceed to signature line at bottom of page.

Please check one of the following:

□ Your serious health condition (certification may be required) (OFLA/FMLA) (See following pages.)
□ Family members with serious health condition (certification may be required) (OFLA/FMLA)
□ Child requiring home care (OFLA)
□ Pregnancy (includes prenatal care, childbirth, and recovery) (OFLA/FMLA)
□ Care for a newborn child (OFLA/FMLA)
□ Placement/Adoption of child or adult dependent (OFLA/FMLA)
□ Parent-in-law with condition that poses imminent danger of death, is terminal or requires constant care (OFLA)
□ Military caregiver (certification may be required) (OFLA/FMLA)
□ Military exigency (OFLA/FMLA)

Do you have a spouse who works for the college who is requesting time off for the same purpose? ☐ Yes ☐ No

(Restrictions may apply, OAR 839-009-0240. Contact HR Director.)

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.)

Employee Signature: ____________________________________________

Confidentiality: 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.

☐ Leave Approved ☐ Not Approved Supervisor’s Signature: ____________________________