738 NE DAVIS ST
PORTLAND, OR 97232
503-542-4615 (direct line)
503-542-4623 (confidential fax)

FAMILY AND MEDICAL LEAVE REQUEST FORM

PART 1: TO BE COMPLETED BY EMPLOYEE (Please Type or Print)

1a. Name of employee (first, middle initial, last): 1b. Address: Phone No.:	2a. Employer: Janus Youth Programs, Inc. 2b. Employee's position/title:

3. Reason for requested Family Medical Leave:
   - a) ☐ Care for a newborn child
   - b) ☐ Care for an adopted or foster child
   - c) ☐ Care for spouse, child, parent, same-sex domestic partner, parent-in-law, grandparent or grandchild with a serious health condition
   - d) ☐ Bereavement Leave
   - e) ☐ Care for my own serious health condition which prevents me from performing the functions of my job
   - f) ☐ Care for a covered service member with a serious injury or illness who is a spouse, son, daughter, parent or next of kin
   - g) ☐ Due to a qualifying exigency arising out of a spouse, same-sex and/or registered domestic partner, son, daughter, parent who is on active duty or called to active duty status in a foreign country.

4. If "C" Please check one:
   ☐ Spouse ☐ Child ☐ Parent ☐ Same-sex or registered domestic partner ☐ Parent-in-law ☐ Grandchild ☐ Grandparent ☐ Next of Kin
   ☐ Other:_______

5. If "C," state name and address of relation (if for Bereavement Leave then only give name):

6. Date on which you wish to begin your leave:	7. Date of anticipated return to work:

8. Are you requesting leave on an intermittent (reduced workday hours) or reduced leave (fewer workdays each workweek) schedule? ☐ Yes ☐ No
9. If "yes", please give schedule of when you anticipate you will be unavailable for work:

Employees requesting leave because of reasons "3 (c)" or "3(d)," must complete the attached Certification of Health Care Provider form and return it within 15 days of request to provide or 30 days prior to beginning of leave. Employees requesting leave because of reasons "3(b), 3 (e) or 3(f) will also be provided appropriate forms for completion and documentation of need for leave with a due date for return).
I understand that my leave may be delayed until I return the required documentation and may be denied if I do not submit the required documentation in a timely manner.

Employees returning to work after a leave because of their own serious illness (Reason "3(d)," must also submit a completed *Return to Work Medical Certification Form"* before they are allowed to resume work. I understand that I may not be permitted to resume my position with the organization until I provide a release to return to work from my medical practitioner.

I agree that while I am on leave, I will continue to pay my share of health insurance premiums, if applicable, unless I elect to discontinue coverage. I also agree that if I fail to return to work at the end of the leave period, I will reimburse the organization for the cost of organization-provided health benefits during my unpaid leave, unless I fail to return to work because of the continuation, recurrence or onset of a serious health condition; because, upon commencement of my leave I gave unequivocal notice of my intent not to return to work; or because of other circumstances beyond my control. If I am unable to return to work because of my own or my family member's serious health condition, I will provide medical certification from the appropriate health care provider stating that I am unable to perform the functions of my position on the date that my leave expired or that I am needed to care for my qualified family member because he/she has a serious health condition on the date that my leave expired. Finally, I understand that if I do not return to work on the date indicated above (or another date as specified by me and agreed to by the organization for reasons other than my inability to return to work due to my own or a family member's serious health condition or unless I have received prior approval from the executive director or his/her designee or other circumstances beyond my control, my employment may be terminated by the organization as of the date my leave expired.

Signed: Dated:

Return this form to: Melissa Allen Payroll and Benefits Manager Confidential Fax:503-542-4623	Email: Employeebenefits@janusyouth.org Mail: Janus Youth Programs, Inc. 738 NE Davis Portland, OR 97232

1/2021