Oregon TECH
Human Resources

# Employee Leave Checklist
## *Employee's Own Serious Health Condition*

You may be eligible for leave under the Family Medical Leave Act (FMLA), the Oregon Family Leave Act (OFLA), and/or Oregon Paid Family Medical Leave (PFML). These leaves entitle eligible employees up to 12 weeks of FMLA/OFLA/ PFML in a 12-month period. FMLA/OFLA/PFML protect your job and benefits. FMLA/OFLA leave are not a paid leave unless you utilize PFML, and/or have paid leave time to use. If you have Short Term Disability Insurance, you may be eligible for additional wage replacement benefits.

**STEP 1: INFORMATION TO READ AND REVIEW**

- □ FMLA Employee Rights Notice
- □ OFLA Employee Rights Notice
- □ OIT Notice of Employee Rights

**STEP 2: COMPLETE LEAVE REQUEST FORM**

- □ FMLA/OFLA Leave Request Form – complete and return to HR

**STEP 3: MEDICAL CERTIFICATION**

- □ Medical Certification – give to Medical provider and have them return to HR

**STEP 4: LEAVE AND LEAVE BENEFITS**

- □ If you are located in the State of Oregon and/or if you have Short Term Disability via PEBB
  - Contact The Standard at 1-800-242-1888 (PFML Policy #762196)
- □ Complete your FMLA/OFLA Attendance Record/Leave Tracking Form and your Employee Leave slip every month

**STEP 5: RETURN TO WORK**

- □ Have your medical provider complete the Employee Release to Return to Work Form – return to HR at the time of your return

# Your Employee Rights Under the Family and Medical Leave Act

## What is FMLA leave?

The Family and Medical Leave Act (FMLA) is a federal law that provides eligible employees with **job-protected leave** for qualifying family and medical reasons. The U.S. Department of Labor's Wage and Hour Division (WHD) enforces the FMLA for most employees.

Eligible employees can take **up to 12 workweeks** of FMLA leave in a 12-month period for:

- The birth, adoption or foster placement of a child with you,
- Your serious mental or physical health condition that makes you unable to work,
- To care for your spouse, child or parent with a serious mental or physical health condition, and
- Certain qualifying reasons related to the foreign deployment of your spouse, child or parent who is a military servicemember.

An eligible employee who is the spouse, child, parent or next of kin of a covered servicemember with a serious injury or illness **may take up to 26 workweeks** of FMLA leave in a single 12-month period to care for the servicemember.

You have the right to use FMLA leave in **one block of time**. When it is medically necessary or otherwise permitted, you may take FMLA leave **intermittently in separate blocks of time, or on a reduced schedule** by working less hours each day or week. Read Fact Sheet #28M(c) for more information.

FMLA leave is **not paid leave**, but you may choose, or be required by your employer, to use any employer-provided paid leave if your employer's paid leave policy covers the reason for which you need FMLA leave.

## Am I eligible to take FMLA leave?

You are an **eligible employee** if **all** of the following apply:

- You work for a covered employer,
- You have worked for your employer at least 12 months,
- You have at least 1,250 hours of service for your employer during the 12 months before your leave, and
- Your employer has at least 50 employees within 75 miles of your work location.

Airline flight crew employees have different "hours of service" requirements.

You work for a **covered employer** if **one** of the following applies:

- You work for a private employer that had at least 50 employees during at least 20 workweeks in the current or previous calendar year,
- You work for an elementary or public or private secondary school, or
- You work for a public agency, such as a local, state or federal government agency. Most federal employees are covered by Title II of the FMLA, administered by the Office of Personnel Management.

## How do I request FMLA leave?

Generally, **to request FMLA leave you must**:

- Follow your employer's normal policies for requesting leave,
- Give notice at least 30 days before your need for FMLA leave, or
- If advance notice is not possible, give notice as soon as possible.

You **do not have to share a medical diagnosis** but must provide enough information to your employer so they can determine whether the leave qualifies for FMLA protection. You **must also inform your employer if FMLA leave was previously taken** or approved for the same reason when requesting additional leave.

Your **employer may request certification** from a health care provider to verify medical leave and may request certification of a qualifying exigency.

The FMLA does not affect any federal or state law prohibiting discrimination or supersede any state or local law or collective bargaining agreement that provides greater family or medical leave rights.

State employees may be subject to certain limitations in pursuit of direct lawsuits regarding leave for their own serious health conditions. Most federal and certain congressional employees are also covered by the law but are subject to the jurisdiction of the U.S. Office of Personnel Management or Congress.

## What does my employer need to do?

If you are eligible for FMLA leave, your **employer must**:

- Allow you to take job-protected time off work for a qualifying reason,
- Continue your group health plan coverage while you are on leave on the same basis as if you had not taken leave, and
- Allow you to return to the same job, or a virtually identical job with the same pay, benefits and other working conditions, including shift and location, at the end of your leave.

Your **employer cannot interfere with your FMLA rights** or threaten or punish you for exercising your rights under the law. For example, your employer cannot retaliate against you for requesting FMLA leave or cooperating with a WHD investigation.

After becoming aware that your need for leave is for a reason that may qualify under the FMLA, your **employer must confirm whether you are eligible** or not eligible for FMLA leave. If your employer determines that you are eligible, your **employer must notify you in writing**:

- About your FMLA rights and responsibilities, and
- How much of your requested leave, if any, will be FMLA-protected leave.

## Where can I find more information?

Call **1-866-487-9243** or visit **dol.gov/fmla** to learn more.

If you believe your rights under the FMLA have been violated, you may file a complaint with WHD or file a private lawsuit against your employer in court. **Scan the QR code to learn about our WHD complaint process**.

**WAGE AND HOUR DIVISION**
UNITED STATES DEPARTMENT OF LABOR

SCAN ME

# OREGON FAMILY LEAVE

## You can take time off for pregnancy disability, bereavement or to provide home care for your child under the Oregon Family Leave Act (OFLA).

- **This time is protected, but often unpaid unless you have vacation, sick, or other paid leave available.** However, while on OFLA leave, your employer must let you use any vacation, sick, or other paid leave you have accrued. OFLA leaves are separate from Paid Leave Oregon benefits.
- OFLA applies to employers with 25 or more employees.
- To be eligible, you must have worked an average of 25 hours per week for 180 days. A separation from employment or removal from the schedule for up to 180 days does not count against eligibility. (During a public health emergency, eligibility starts at just 30 days working 25 or more hours per week.)
- You can take up to 12 weeks of time off per year for:
  - **Providing care to your child related to an illness, injury or conditions that requires home care** or when your child's school or child care provider is closed as a result of a public health emergency.
  - **Bereavement** (up to two weeks) for the death of an individual related by blood or affinity.
  - Through 2024, you can also take up to two additional weeks for the legal process required for foster child placement or adoption.
  - **Pregnancy disability leave** In addition to leave for the other reasons listed here, you can take up to 12 additional weeks of time off per year for pregnancy disability before or after the birth of child or for prenatal care.
- Your employer must keep giving you the same health insurance benefits as when you are working. When you come back you must be returned to your former job or a similar position if your old job no longer exists.
- Military family leave (up to 14 days) is also available if your spouse is a service member who has been called to active duty or is on leave from active duty.

## CONTACT US

**If your employer isn't following the law or something feels wrong, give us a call.** The Bureau of Labor and Industries is here to enforce these laws and protect you.

**Call:** 971-245-3844
**Email:** BOLI_help@boli.oregon.gov
**Web:** oregon.gov/boli
Se habla español.

OREGON LAWS
Protect You At Work
July 2024 - June 2025

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Human Resources

# Notice of Employee Rights and Responsibilities
# FMLA/OFLA Leave

**If your leave qualifies for FMLA, OFLA, or PFML leave, you will have the following rights and responsibilities:**

**Leave Entitlement:** Effective the first day of your leave, time taken under the protected leave laws is counted against your leave entitlement. Generally, you are entitled to 12 weeks of protected leave in a rolling forward 12-month period. The rolling 12-month period is measured forward from the Sunday proceeding the date of any protected leave usage. Some leave types may be entitled to additional protected leave.

**Paid Leave:** You will be required to use your paid accruals (sick, vacation, etc.) during your FMLA/OFLA leave unless you are receiving the benefits of PFML, or short- or long-term disability. This means you will use your paid leave (sick, vacation, etc.) and that such leave will also be considered protected under the FMLA/OFLA leave and counted against your protected leave entitlement.

- All Employees must use available accrued sick leave during FMLA/OFLA leave, unless the employee is on approved FMLA and is utilizing his/her short-term disability benefit, long-term disability benefits, or the benefits of PFML.

- Classified Employees: Classified employees must use all accrued vacation leave during FMLA/OFLA leave before going into unpaid status (leave without pay), unless the employee is on approved FMLA, OFLA, and/or PFML and is utilizing short-term disability benefits, long-term disability benefits, or the benefits of PFML. See the Oregon Public Universities/SEIU Collective Bargaining Agreement, Article 47-Vacation Leave, Section 14, regarding an employee's option to retain up to 40 hours of accrued vacation leave.

  Upon exhausting all accrued sick leave, classified employees may use accrued vacation leave, compensatory/exchange time, and/or personal leave during FMLA/OFLA/PFML leave.

  After exhausting all paid leave, classified employees may request hardship leave donations. See the Oregon Public Universities/SEIU Collective Bargaining Agreement, Article 40 – Sick Leave, Section 8.

- Unclassified Administrative Employees: Upon exhausting all accrued sick leave, unclassified employees may use accrued vacation leave time during FMLA, OFLA, and/or PFML leave before going into unpaid status (leave without pay). You may also elect to retain up to 40 hours of accrued vacation leave as described in the policy.

- Faculty: Upon exhausting all accrued sick leave, unclassified employees may use accrued vacation leave time during FMLA/OFLA/PFML leave before going into unpaid status (leave without pay).

- Employees may not go in and out of unpaid status, unless on approved FMLA/OFLA and receiving short-term or long-term disability benefits through Standard Insurance, or the benefits of Paid Leave Oregon.

**Benefits:** Approved FMLA, OFLA, and PFML Leaves: Your health insurance coverage will continue provided you continue to contribute your portion of the premiums. Premiums will be deducted through normal payroll deduction when available. An employee who is in leave without pay status during FMLA, OFLA, or PFML leave will be responsible to self-pay their portion of health insurance premiums directly to the University. Employee paid optional benefit premiums may be also be continued when self-paid by the employee.

If you do not return to work following FMLA and/or OFLA leave you may be required to reimburse the University for the employer share of health insurance premiums paid on your behalf during your leave.

**Medical Certification:** In order to determine whether an employee's absence qualifies for protected leave under the FMLA and OFLA leave laws, you may be required to provide a medical certification from a qualified health care provider within 15 calendar days of the receipt of your notice for eligibility to take protected leave. It is the employees' responsibility to ensure a complete and sufficient medical certification is returned to Human Resources within the designated timeframe. When utilizing the benefits of PFML medical certification will also be required to support your claim, The Standard will provide you with the required paperwork for this.

While on approved FMLA or OFLA leave, you may be required to provide additional medical certifications if requested by Human Resources. The interval between re-certifying will not be less than 30 days, unless the circumstances for your leave have changed significantly.

Failure to provide a complete and sufficient Medical Certification may result in your leave being denied. Denied FMLA and/or OFLA is not protected under the leave statutes and the University may treat the absences as unexcused.

**Periodic Check In:** While on leave, you are required to check in periodically with Human Resources. You should provide information on your status, any change in circumstances, and if out for a continuous block of time, your intent to return work.

**Status Changes:** You are required to notify Human Resources if the status of your leave requirements changes. Status changes may include, but are not limited to: a need for continuous leave while on approved intermittent leave; a need for more intermittent leave than the amount currently approved; or a need for leave beyond the current approved end date. If you are on approved leave and no longer require time off for the approved reason, please contact Human Resources to close your file.

**Leave Reporting:** You are required to record any FMLA/OFLA/PFML leave taken on a leave tracking form which should be provided to Human Resources monthly, typically by the 5$^{th}$ of the following month.

**Return to Work:** If the status of your situation changes and you do not anticipate returning on your scheduled return date, you are expected to notify your supervisor and the Human Resources office as soon as possible.

When you return, you must be able to carry out the essential functions of your position. If your leave was for your own Serious Health Condition, you will be required to provide either a Return to Work form or a medical certification stating you are able to return to work without restrictions. If there are restrictions associated with your return to work, please contact Human Resources, so those restrictions can be reviewed and evaluated to determine if we are able to provide Reasonable Accommodations on a temporary basis.

**Reinstatement Rights:** Upon returning from protected leave, you have the following reinstatement rights:

- FMLA: You must be reinstated to either the same position held when leave began or to an equivalent position. An equivalent position is one that is virtually the same as the employee's former position in terms of pay, benefits, and working conditions and must involve the same or substantially similar duties and responsibilities.
- OFLA/PFML: You must be reinstated to the position held when the leave began.

If you remain on leave after exhausting your protected leave entitlement (FMLA, OFLA, and/or PFML), you will not have the reinstatement rights outlined above.

For additional information pertaining to leave, contact Human Resources at 541-885-1028.

Oregon TECH
Human Resources

# Leave of Absence Request Form

| EMPLOYEE INFORMATION | | | | |
|---|---|---|---|---|
| **Name:** | | **ID#:** | | |
| **Department:** | | **Job Title:** | | |
| **Employee Type:** | ☐ Classified | ☐ Faculty | ☐ Unclassified Admin | ☐ Student Employee |
| **Supervisor Name:** | | | | |
| **Contact information while on leave** | | | | |
| **Personal Email:** | | | | |
| **Mailing Address:** | | | | |
| **Phone:** | | | | |

**LEAVE INFORMATION**

**I am requesting a leave of absence for the following reason:**

| | |
|---|---|
| ☐ My own serious health condition | ☐ To care for my family member with a serious health condition |
| ☐ Birth of my child, and/or to care for the newborn child or placement of a child for adoption/foster care | ☐ Qualifying military exigency leave |
| ☐ My child's NON-SERIOUS health condition | ☐ Service member care leave (SMCL) |
| | ☐ Bereavement leave |

If applicable, please specify the person the leave is for and the relationship:

| | |
|---|---|
| Name: | |
| Relationship: | |

| | | | |
|---|---|---|---|
| Is the condition due to an on-the-job injury or illness? | ☐ Yes | ☐ No | ☐ N/A |

**I am requesting a leave of absence with the following schedule** *(MM/DD/YYYY)*:

| | | | |
|---|---|---|---|
| ☐ Full-time leave from | | to | |
| ☐ Intermittent leave from | | to | |
| ☐ Reduced-schedule leave from | | to | |

Describe proposed intermittent or reduced schedule:

**COMPENSATION DURING LEAVE**

| | | | |
|---|---|---|---|
| Will you be applying for Short Term Disability (STD)? | ☐ Yes | ☐ No | ☐ N/A |
| Will you be using leave during any STD waiting period? | ☐ Yes | ☐ No | ☐ N/A |
| Will you be using leave to supplement your STD payment? | ☐ Yes | ☐ No | ☐ N/A |
| Will you be applying for Paid Family Medical Leave (PFML)? | ☐ Yes | ☐ No | ☐ N/A |
| Will you be using leave to supplement you PFML payment? | ☐ Yes | ☐ No | ☐ N/A |

**Please list the types of leaves you wish to use in sequence**

| Type of Leave | 1st | 2nd | 3rd | 4th | 5th | N/A |
|---|---|---|---|---|---|---|
| Leave without Pay | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| Sick Leave | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| Vacation | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| Compensatory/Exchange Time (Classified Only) | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| Personal Days (Classified Only) | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| Use my special day on: | | | | | | |
| I will use paid holidays on: | | | | | | |

I wish to retain _____ hours of vacation *(classified & unclassified admin only, 40 hours max)*

_____ _____

**Employee Signature** **Date**

# Oregon and Federal Family and Medical Leave
# Health Care Provider Certification

This form is to be completed by physician or other health care provider and returned to:
☐ the employee, or ☐ the employer (below):
Oregon Tech, Attn: Sarah Henderson-Wong, Fax 541.851.5200

Information sought on this form relates only to the condition for which the employee is taking leave.

**Employee's Name:** _____

**Patient's Name** (if different from employee)**:** _____

**1.** On the reverse of this sheet is a description of various "serious health condition" categories that qualify under the Family and Medical Leave Acts. Please check appropriate category or categories:

☐ 1-Hospital care ☐ 3-Pregnancy and/or prenatal care ☐ 5-Perm/long-term condition requiring supervision
☐ 2-Absence plus treatment ☐ 4-Chronic condition requiring treatment ☐ 6-Multiple treatments (non-chronic condition)

**2.** Provide a description of the medical facts that support your certification and explain how they meet the criteria of the category: _____

_____

**3.** Approximate date condition began and probable duration: from __/__/__ through __ /__/__

**4.** Probable duration of patient's present incapacity (if different): from ___/___/___ through __ /___/___

**5.** If this is a chronic condition or pregnancy, is the patient presently incapacitated (see reverse side for definition)?

☐ Yes ☐ No If yes, duration and frequency of episodes of incapacity: _____

**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? ☐ Yes ☐ No If yes, duration: _____

Frequency: ☐ One to two days per month ☐ Two to three days per month ☐ Three to four days per month

☐ Other: Please explain how the employee will use leave intermittently or work a less than full-time schedule, being as specific as possible including frequency and duration of absences:

_____

**7.** If the patient requires a regimen of treatment, what is the nature of and description of the treatments, estimated number of treatments, and intervals between treatments (see reverse side for definition)? _____

_____

What are the actual or estimated dates of visits for treatment, or frequency of visits for treatment? _____

What is the duration of each treatment and any period required for recovery? _____

***8. 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, safety, or for transportation? ☐ Yes ☐ No

b. If no, would the employee's presence to provide psychological comfort be beneficial or assist in the patient's recovery? ☐ Yes ☐ No

c. If the patient will need care only intermittently or on a part-time basis, please indicate the probable duration and frequency of this need: _____

_____ _____
*Printed Name of Physician/ Practitioner* *Date Signed*

_____ _____
*Signature of Physician/ Practitioner* *Type of Practice/ Field of Specialization*

_____ _____
*Address* *Phone Number*

## HEALTH CARE PROVIDER CERTIFICATION form (continued)

Federal and Oregon Family and Medical Leave Acts

**Definition of a "Serious Health Condition":**

**A "serious health condition" is defined as an illness, impairment, physical or mental condition that involves one of the following:**

**1. Hospital care –**
Inpatient care (i.e., overnight stay) in a hospital, hospice, or residential medical care facility, including any period of incapacity or subsequent treatment in connection with or consequent to such inpatient care.

**2. Absence plus treatment –**
A period of incapacity of more than three consecutive calendar days (including any period of incapacity or subsequent treatment relating to the same condition), that also involves:

(a) Treatments two or more times by a licensed healthcare provider, nurse, or physician's assistant under direct supervision of a healthcare provider, or by a provider of healthcare services (e.g., physical therapist) under orders of, or on referral by, a healthcare provider, ***or***

(b) Treatment by a healthcare provider on at least one occasion which results in a regimen of continuing treatment under supervision of the healthcare provider.

*(1) Treatment includes examinations to determine if a serious health condition exists and evaluations of the condition. Treatment DOES NOT include routine physical, dental, or eye examinations.*

*(2) A regimen of continuing treatment includes, for example, a course of prescription medication (e.g., an antibiotic) or therapy requiring special equipment to resolve or alleviate the health condition. A regimen of treatment DOES NOT include the taking of over-the-counter medications such as aspirin, antihistamines, or salves; or bed-rest, drinking fluids, exercise, or any other similar activities that can be initiated without a visit to a healthcare provider.*

**3. Pregnancy –**
Any period of incapacity due to pregnancy, pregnancy-related illness, or for prenatal care.

**4. Chronic conditions requiring treatments –**
A chronic serious health condition is one which:

(a) Requires periodic visits for treatment by a healthcare provider, nurse, or physician's assistant under direct supervision of a healthcare provider;

(b) Continues over an extended period of time (including recurring episodes of a single underlying condition); and

(c) May cause episodic rather than continuing periods of incapacity (e.g., asthma, diabetes, epilepsy, etc.)

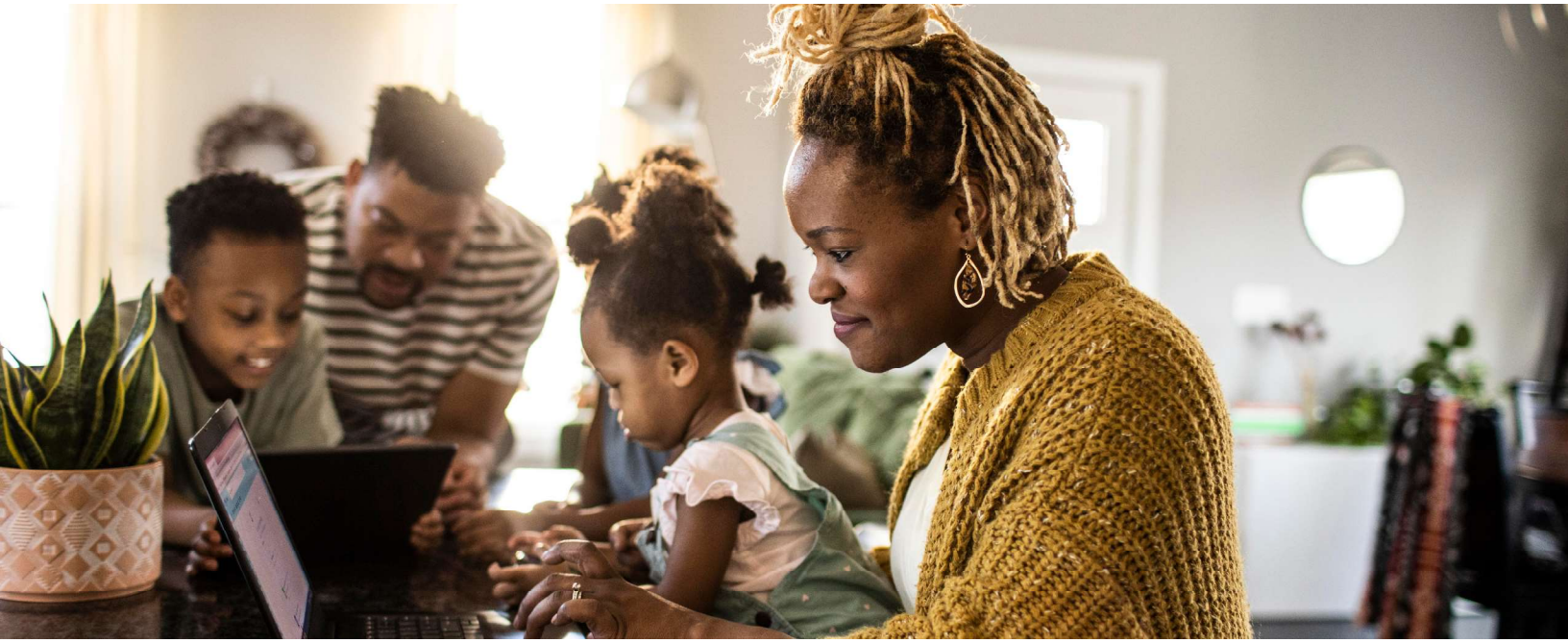
**5. Permanent/ long-term conditions requiring supervision –**
A period of incapacity that is permanent or long-term due to a condition for which treatment may not be effective. The employee or family member must be under the continuing supervision of, but need not be receiving active treatment by, a healthcare provider. Examples include Alzheimer's, a severe stroke or the terminal states of a disease.

**6. Multiple treatments (non-chronic conditions) –**
Any period of absence to receive multiple treatments (including any period of recovery therefrom) by a healthcare provider or by a provider of healthcare services under orders of, or on referral by, a healthcare provider, either of restorative surgery after an accident or other injury, or for a condition that would likely result in a period of incapacity of more than three consecutive calendar days in the absence of medical intervention or treatment, such as cancer (chemotherapy, radiation, etc.), severe arthritis (physical therapy), kidney disease (dialysis).

**Definition of "Incapacitated":** Inability to work, attend school, or perform other regular daily activities due to the serious health condition, treatment therefore, or recovery therefrom.

**Directions regarding "Regimen of treatment" (question 5):** If the patient is under your supervision, provide a general description of such regimen, such as prescription drugs or physical therapy requiring special equipment. If the treatments will be provided by another provider of health services, such as a physical therapist, please state the nature of the treatments.

# Reporting an Absence
# Oregon Paid Family and Medical Leave



## WHEN SHOULD I REPORT AN ABSENCE?

You should report an absence to Standard Insurance Company (The Standard‡) if you're absent from work or know you'll be absent from work for any of the following reasons:

- **Your own serious health condition, including pregnancy**
- **Bonding with a child in the first 12 months after birth, adoption or foster care placement**
- **Caring for a qualifying family member with a serious health condition**
- **Safe leave for those experiencing or managing the impacts of family violence**

## HOW SHOULD I REPORT AN ABSENCE?

Contact The Standard's Services Center at:
**800.242.1888**

Please reference the following:
Oregon Institute of Technology | Policy# 762196

Remember to stay in contact with both us and your employer throughout your leave.

## WHAT ARE THE CENTER'S HOURS OF OPERATION?

Monday through Friday
5 a.m. – 5 p.m. Pacific

## WHAT ABOUT OTHER TIMES I'LL BE OUT?

For all other absences, please follow your typical department process. If you have questions, contact the Office of Human Resources.

Standard Insurance Company | 1100 SW Sixth Avenue, Portland, OR 97204 | standard.com



OR PFML Admin Poster - AMS & TCI
**OR-Template**
(4/23)

SI **23070**

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Human Resources

# FMLA/OFLA ATTENDANCE RECORD / LEAVE TRACKING FORM

**Name:** _____
**Department:** _____
**Employee ID#:** _____
**Instructions:** Please record the number of hours you were off each day while on FMLA/OFLA leave. Include holidays.
Do not include days you would not have been expected to be at work (your normal days off).
Return this form at the end of each month.

| Month | Year | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | 11 | 12 | 13 | 14 | 15 | 16 | 17 | 18 | 19 | 20 | 21 | 22 | 23 | 24 | 25 | 26 | 27 | 28 | 29 | 30 | 31 | Total |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Jan | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | 0.00 |
| Feb | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | 0.00 |
| Mar | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | 0.00 |
| Apr | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | 0.00 |
| May | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | 0.00 |
| Jun | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | 0.00 |
| Jul | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | 0.00 |
| Aug | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | 0.00 |
| Sep | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | 0.00 |
| Oct | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | 0.00 |
| Nov | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | 0.00 |
| Dec | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | 0.00 |

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

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

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# Employee Release to Return to Work

Return form to: Oregon Institute of Technology
3201 Campus Drive, Snell 111
Klamath Falls, OR 97601
Phone: 541-885-1028
Fax: 541-851-5200

Employee _____ ID # _____
Position/Job _____

## SECTION 1: WORK STATUS *(Select one)*

☐ **OPTION 1 – Released to Regular Work** Status from (date): _____ to: _____
Released to the ***hours routinely worked and tasks routinely performed in job at the time of injury/illness.***

☐ **OPTION 2 – Not Released to Work** Status from (date): _____ to: _____
The employee 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/limitations (note only those applicable):***

**Total work hours:** _____ hours/day _____ days/week

## SECTION 2: PHYSICAL COMPONENTS

Does employee have any physical conditions which would impact return to work? ☐ Yes ☐ No
*If none, please skip to Section 3: Cognitive/Psychological Components*
Is the employee expected to materially improve from medical treatment or the passage of time? ☐ Yes ☐ No

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

**Foot use restrictions**

| | | |
|---|---|---|
| ***Raise*** | ____ hrs./day L foot | ____ hrs./day R foot |
| ***Push:*** | ____ hrs./day L foot | ____ hrs./day R foot |

## SECTION 3: COGNITIVE/PSYCHOLOGICAL COMPONENTS

| | |
|---|---|
| Does employee have any cognitive or psychological conditions which would impact return to work?<br>*If no, please skip to Section 4: Other Restrictions* | ☐ Yes ☐ No |
| Is the employee expected to materially improve from treatment or the passage of time? | ☐ Yes ☐ No |
| Statement of psychological/cognitive diagnosis(es) (include DSM-V diagnosis): | |
| How often is employee receiving treatment from you and/or another health care provider for this condition? | |
| Please identify functional limitations of diagnosis(es) based on current status of employee: | |
| Employee has the ability to meet the cognitive demands of the job as described in the position description. | ☐ Yes ☐ No |
| Employee has the ability to meet the psychological demands of the job as described in the position description. | ☐ Yes ☐ No |
| Employee has the ability to multitask without significant loss of efficiency or accuracy. This includes the ability to perform multiple duties from multiple sources. | ☐ Yes ☐ No |
| Employee has the ability to work and sustain attention with distractions and/or interruptions. | ☐ Yes ☐ No |
| Employee is able to interact appropriately with a variety of individuals including students, customers, clients, colleagues, and the public. | ☐ Yes ☐ No |
| Employee is able to deal with people under challenging circumstances. | ☐ Yes ☐ No |
| Employee has the ability to work as an integral part of a team. Includes ability to maintain workplace relationships. | ☐ Yes ☐ No |
| Employee is able to maintain regular attendance and be punctual. | ☐ Yes ☐ No |
| Employee is able to understand, remember and follow simple verbal and written instructions. | ☐ Yes ☐ No |
| Employee is able to understand, remember and follow detailed verbal and written instructions. | ☐ Yes ☐ No |
| Employee is able to complete assigned tasks with minimal or no supervision. | ☐ Yes ☐ No |
| Employee is able to exercise independent judgement and make decisions. | ☐ Yes ☐ No |
| Employee is able to perform under stress and/or in emergencies. | ☐ Yes ☐ No |
| Employee is able to perform in situations requiring speed or productivity quotas. | ☐ Yes ☐ No |
| *Clarify or add any additional information here:* | |

## SECTION 4: OTHER RESTRICTIONS

| | |
|---|---|
| If there are other job restrictions you have not described elsewhere, please describe here: | |
| Is the employee currently prescribed medication that would impair job function or safety? If so, please describe: | |
| Are all listed work restrictions medically necessary? | ☐ Yes ☐ No |

## SECTION 5: CERTIFICATION

I certify that the information provided in this form is true and correct to the best of my knowledge.

Medical provider's signature: _____ Date: _____

Print provider's name: _____ Phone: _____