CITY OF Salem AT YOUR SERVICE

PROTECTED LEAVE APPLICATION FORM

Employee Name:

Date of Hire:

Dept/Division: IAFF: ☐ 40 hour ☐ 56 hour

Work Phone: _____

Home Address: _____ City/Zip: _____

Contact Phone: _____

Applying for Paid Leave Oregon ☐ Yes ☐ No

If you are using Paid Leave Oregon, do you want to receive supplemental City wages? ☐ Yes ☐ No

Anticipated Leave Start Date: _____ End date: _____

Is leave requested on an intermittent basis? ☐ Yes ☐ No (If yes, a protected leave schedule is required. Please be sure to include frequency/duration. Example: One day per month.)

REASON FOR PROTECTED LEAVE:

☐ **Birth of a Child / Adoption or Placement of a Child –**

Anticipated delivery date or physical custody of child:

☐ **Employee's Serious Health Condition –** Complete and return Medical Certification Form

☐ **Care of Seriously Ill Family Member –** Complete and return Medical Certification Form

Name of ill family member: _____

Relationship to employee: _____

☐ **Bereavement Leave –**For spouse, child, parent, parent-in-law, grandparent, grandchild, or other family defined by CBA: _____

☐ **Military Leave –** (Reserve Training or Recall to Active Duty) attach orders

☐ **Military Qualifying Exigency Leave –** ☐ spouse; ☐ child; or ☐ parent, who is on active duty or call to active duty status in support of a contingency operation as a member of Nation Guard Reserve.

☐ **Military Caregiver Leave –** To care for a: ☐ spouse, ☐ child; or ☐ parent; ☐ next of kin, of a covered service member or veteran with a serious injury or illness.

CITY OF Salem
AT YOUR SERVICE

PROTECTED LEAVE APPLICATION FORM

☐ **Crime Victims Leave**

☐ **Safe Leave**

I understand that my leave may be delayed until the proper documentation is returned. I understand that in the case of my own serious health condition, I may not be permitted to resume my position with the City until I provide a completed Fitness for Duty document from my provider. City policy requires, with the exception of IAFF/Military Leave, employees use all accrued sick leave followed by other accrued leaves before a period of unpaid leave. I agree that while I am on leave, I will continue to pay my share of any insurance premiums, as 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 may be required to reimburse the City for the City's share of provided health benefits during my leave in accordance with regulations. Finally, I understand that if I do not return to work on the date indicated above (or as applicable and agreed to by the City), my employment may be terminated by the City as of the date my leave expires.

Employee's Signature:_____ Date: _____