Clackamas Community College

Code: **GAB**
Adopted: 8/03/94
Revised/Readopted: 12/14/11; 5/09/18
Orig. Code: 601

Job Description

Current job descriptions will be maintained by the College human resources office. All job descriptions shall comply with all applicable state and federal laws.

An employee requesting a copy of their job description will be provided one without cost to the employee. Job descriptions will be used as a reference for employee evaluations.

END OF POLICY

Legal Reference(s):

OAR 589-008-0100(1)(c)

Americans with Disabilities Act of 1990, 42 U.S.C. §§ 12101-12213 (2012); 29 C.F.R. Part 1630 (2016); 28 C.F.R. Part 35 (2016).
Vietnam Era Veterans' Readjustment Assistance Act of 1974, as amended, 38 U.S.C. § 4212 (2012).
Title II of the Genetic Information Nondiscrimination Act of 2008.
Section 503 of the Rehabilitation Act of 1973.
Americans with Disabilities Act Amendments Act of 2008.

Cross Reference(s):

ACA - Americans with Disabilities Act

Delete

Position Descriptions

Job descriptions serve:

1. To describe all essential functions that the individual who holds the position must be able to perform unaided or with the assistance of a reasonable accommodation;

2. To describe attendance standards;

3. To help applicants determine the qualifications needed to fill a position;

4. To help administrators/supervisors determine which candidates to recommend for appointment; and

5. To assist administrators/supervisors in the evaluation of the employee's performance of position responsibilities.

"Essential functions" as used in this policy means the fundamental job duties of the employment position. A job function may be considered essential for any of several reasons, including but not limited to the following:

1. The function may be essential because the reason the position exists is to perform the function;

2. The function may be essential because of the limited number of employees available among whom the performance of the job function can be distributed; and/or

3. The function may be highly specialized so that the individual is hired for his/her expertise or ability to perform the particular function.

"Attendance standards," as used in this policy means the regular work hours of the position, including leave and vacation provisions available through policy and/or collective bargaining agreements and any special attendance needs of the position as determined by the College.

Job descriptions will be developed under the supervision of the President for each position in the College. Each job description shall be dated. As job descriptions are reviewed and/or revised new dates will be affixed.

Delete

Job descriptions will be coded and retained in the Human Resources Office. The job descriptions will be available for inspection by any College employee or patron. Each employee shall receive a copy of his/her job description. Each full-time employee shall affix his/her signature and date after having read the job description.

The President or designee will oversee that job descriptions are reviewed and revised, as needed.

Approved by President's Council: December 6, 2011
(Date)

Delete

Clackamas Community College

Code: **GBEBA**
Adopted: 1/11/06
Revised/Readopted: 12/14/11; 5/09/18
Orig. Code: 408

HIV Infection or AIDS

The College recognizes the importance of information and education relating to AIDS (Acquired Immune Deficiency Syndrome) and HIV (Human Immunodeficiency Virus). The College also recognizes the need to provide proper protection for its students and staff, while remaining sensitive to the needs of any student or staff member with HIV infections or AIDS.

Consistent with current medical evidence that AIDS is not transmissable through casual work or campus contact, the Board hereby declares the following statements, relating to students or staff members infected with HIV, including those with AIDS, as policy until such time as new medical or legal information mandates update or change:

1. The College will not require employees, applicants for employment or students to be tested for the HIV;

2. Confidentiality concerning employees and students will be maintained. Self-disclosure is voluntary;

3. All students and staff will be allowed to participate in all phases of College life including classes, programs, activities and employment consistent with established College policies;

4. Coverage under employee benefit packages will continue to be consistent with bargaining agreements;

5. Any employee refusing to work with another employee or student having, or suspected of having HIV infection or AIDS, will be provided with educational information in an attempt to allay their fears. If the employee still refuses to work, that employee may be subject to disciplinary action up to and including dismissal.

END OF POLICY

Legal Reference(s):

ORS 243.650
ORS 342.850(7)
ORS 433.008
ORS 433.045
ORS 433.260
OAR 333-012-0270
OAR 333-017-0000
OAR 333-018-0000
OAR 333-018-0005
OAR 581-022-0705

Delete

Request for Family and Medical Leave

Employee Request for Family and Medical Leave (FMLA)
and/or Oregon Family Leave (OFLA)

PLEASE PRINT

Where the need for the leave may be anticipated, written request for family and medical leave must be made, if practical, at least 30 days prior to the date the requested leave is to begin. Failure to request leave in a timely manner could result in either the leave being postponed or the amount of leave available reduced up to three weeks.

Name ______________________ Effective Date of the Leave ______________________

Department ______________________ Title ______________________

Status: ☐ Full-time ☐ Part-time ☐ Temporary

Hire Date ______________________ Length of Service ______________________

Have you taken a family leave in the past 12 months? ☐ Yes ☐ No
If yes, how many work days? ____________ Reason for leave ______________________

I request family or medical leave for one or more of the following reasons:[1]

______1. Because of the birth of my child and in order to care for him or her. (College: Use GCBDA/GDBDA-AR(3)(A) Certification Form)
Expected date of birth ____________ Actual date of birth ____________
Leave to start ____________ Expected return date ____________

______2. Because of the placement of a child with me for adoption or foster care. (College: Use GCBDA/GDBDA-AR(3)(A) Certification Form)
Age of child ____________ Date of placement ____________
Leave to start ____________ Expected return date ____________

______3. In order to care for a family member[2] with a serious health condition. (College: Use GCBDA/GDBDA-AR(3)(B) Certification Form)
Leave to start ____________ Expected return date ____________
Please check one: ☐ Spouse ☐ Same-sex domestic partner (OFLA leave only) ☐ Child ☐ Child of same-sex domestic partner (OFLA leave only) ☐ Parent ☐ Parent-in-law, parent of employee's same-sex domestic partner, custodial parent, noncustodial parent, adoptive parent, foster parent ☐ step child ☐ Grandparent or grandchild (OFLA leave only.)

Please state name and address of relation:

Name ______________________ Address ______________________

[1]A physician's certification may be required to support a request for family and medical leave. In addition, a fitness for duty certification may be required before reinstatement following the leave.
[2]"Family member" means the spouse, same-sex domestic partner, custodial parent, noncustodial parent, adoptive parent, foster parent, biological parent, grandparent, parent-in-law, parent of employee's same-sex domestic partner or a person with whom the employee is or was in a relationship of "in loco parentis." It also includes the biological, adopted, grandchild or foster child or stepchild of an employee, child of same-sex domestic partner or a child with whom the employee is or was in a relationship of "in loco parentis."

Delete

Does the condition render the family member unable to perform daily activities?
____

______4. For a serious health condition which prevents me from performing my job functions. (College: Use GCBDA/GDBDA-AR(3)(A) Certification Form)
Describe ____

____

Leave to start ________________________ Expected return date __________________

Regarding 3 or 4 above, request intermittent (reduced workday hours) or reduced leave (fewer workdays each workweek) schedule or alternate duty (if applicable, subject to employer's approval). Please describe schedule of when you anticipate you will be unavailable to work:
____

______5. In order to care for a child with a condition requiring home care which does not meet the definition of serious health condition and is not life threatening or terminal (OFLA leave only).

______6. A qualifying exigency arising from an employee's spouse, son, daughter, or parent who is a covered service member as defined in GCBDA/GDBDA-AR(1), or leave for the spouse or domestic partner of a military personnel per each deployment of the spouse or domestic partner when the spouse or domestic partner has either been notified of an impending call to active duty, has been ordered to active duty, or has been deployed or on leave from deployment. (College: Use GCBDA/GDBDA-AR(3)(C) Certification Form)

______7. To care for a spouse, son, daughter, parent, or next of kin[3] who is a covered servicemember with a serious illness or injury incurred in the line of duty or active duty in the armed forces. Has leave been taken for the same servicemember and the same injury? □ Yes □ No (College: Use GCBDA/GDBDA-AR(3)(D) Certification Form) If yes, when was the leave taken and for how many work days? __________________

I understand that the college requires me to use any accrued sick leave, vacation, personal leave days or other paid time established by Board policy(ies) and/or collective bargaining agreement in the order specified by the college, and before taking leave without pay, for the family and medical leave period.

If my request for a leave is approved, it is my understanding that without an authorized extension when the need for an extension could be anticipated, I must report to duty on the first workday following the date my leave is scheduled to end. I understand that failure to do so will constitute unequivocal notice of my intent not to return to work and the college may terminate my employment. (A fitness-for-duty statement may be required.)

I authorize the college to deduct from my paychecks any employee contributions for health insurance premiums, life insurance or long-term disability insurance which remain unpaid after my leave, consistent with state and/or federal law.

I have been provided a copy of the college's family and medical leave policy and a copy of my rights and responsibilities under the Family Medical Leave Act leave request form.

Signature of Employee: ____ Date: ______________________________

Approved by President's Council: May 22, 2012
(Date)

Delete

[3]"Next of kin" means the nearest blood relative of the eligible employee.

Certification of Health Care Provider

Employee's Serious Health Condition

To be completed by the College:

The Family Medical Leave Act (FMLA) provides that a College may require an employee seeking FMLA leave protections because of a need for leave due to a serious health condition to submit a medical certification issued by the employee's health care provider. Employees may not be asked to provide more information than allowed under the FMLA regulations. The College will maintain records and documents relating to medical certification, recertifications, or medical histories of employee's family members, created for FMLA purposes, as confidential medical records in separate files from personnel files and in accordance with 29 C.F.R. § 1630.14(c)(1), if the Americans with Disabilities Act applies.

College contact person:____

Employee's job title:_______________________ Regular work schedule:_______________________

Employee's essential job functions____

____

Check if job description is attached: □

To be completed by the employee:

Complete the information below before giving this form to your family member or his/her medical provider. The return of this form is required to obtain or retain the benefit for FMLA protections. Failure to provide a complete and sufficient medical certification may result in a denial of your FMLA request.

Return this completed form on ______________________________ (must be at least 15 days after employee is notified of this requirement).

Employees name: ____
First Middle Last

Delete

To be completed by health care provider:

Your patient has requested leave under the FMLA. Answer, fully and completely, all applicable parts below. Several questions seek a response as to the frequency or duration of a condition, treatment, etc. Your answer should be the 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 coverage. Limit your responses to the condition for which the employee is seeking leave. Extra space is provided, should you need it. Please be sure to sign the form on the last page.

Providers’s name and business address:____

____

Type of practice/Medical specialty:____

Telephone: (______)________________________________ Fax:(_______)______________________________

Medical Facts

1. Approximate date condition commenced:____

   Probable duration of condition:____

   Was the patient admitted for an overnight stay in a hospital, hospice or residential medical care facility?
   □ Yes □ No If yes, dates of admission:____

   Dates(s) you treated the patient for condition ____

   Was medication, other than over-the-counter medication, prescribed? □ Yes □ No

   Will the patient need to have treatment visits at least twice per year due to the condition?
   □ Yes □ No

   Was the patient referred to other health care provider(s) for evaluation or treatment (e.g., physical therapist)?
   □ Yes □ No

   If yes, state the nature of such treatments and expected duration of treatment:

   ____

   ____

   ____

2. Is the medical condition pregnancy? □ Yes □ No

   If yes, expected delivery date:________________________

Delete

3. Use the information provided by the College in the “To be completed by the College” section to answer this question. If the College 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.

   Is the employee unable to perform any of his/her job functions due to the condition:
   □ Yes □ No If yes, identify the job functions the employee is unable to perform:

   ____

4. 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):

   ____

   ____

   ____

Amount of leave needed

1. Will the employee be incapacitated for a single continuous period of time due to his/her medical condition, including any time for treatment and recovery? □ Yes □ No

   If yes, estimate the beginning and ending dates for the period of incapacity:____________________________

   ____

2. Will the employee need to attend follow-up treatment appointments or work part-time or on a reduced schedule because of the employee’s medical condition? □ Yes □ No

   If yes, are the treatments or the reduced number of hours of work medically necessary?
   □ Yes □ No

   Estimate treatment schedule, if any, including the dates of any scheduled appointments and the time required for each appointment, including any recovery period:

   ____

   Estimate the part-time or reduced work schedule the employee needs, if any:

   ___________ hour(s) per day; ________ days per week from _______________ through ___________________

3. Will the condition cause episodic flare-ups periodically preventing the employee from performing his/her job functions? □ Yes □ No

   Is it medically necessary for the employee to be absent from work during the flare-ups?
   □ Yes □ No If yes, explain: ____

   ____

Delete

Based upon the employee's medical history and your knowledge of the medical condition, estimate the frequency of flare-ups and the duration of related incapacity that the employee may have over the next six months (e.g., one episode every three months lasting one to two days):

Frequency: ___________times per _____________week(s) _________ month(s)

Duration: _____________hours or ______________day(s) per episode

Additional Information – Identify the question number with your additional answer:

____

____

____

____

____

____ _______________________________

Signature of health care provider Date

Approved by President's Council: May 22, 2012
(Date)

Delete

Certification of Health Care Provider

Family Member's Serious Health Condition

To be completed by the College:

The Family Medical Leave Act (FMLA) provides that a College may require an employee seeking FMLA leave protections because of a need for leave to care for a covered family member with a serious health condition to submit a medical certification issued by the health care provider of the covered family member. Employees may not be asked to provide more information than allowed under the FMLA regulations. The College will maintain records and documents relating to medical certification, recertifications or medical histories of employee's family members, created for FMLA purposes, as confidential medical records in separate files from personnel files and in accordance with 29 C.F.R. § 1630.14(c)(1), if the Americans with Disabilities Act applies.

Contact person:________________________________

To be completed by the employee:

Complete the information below before giving this form to your family member or his/her medical provider. The return of this form is required to obtain or retain the benefit for FMLA protections. Failure to provide a complete and sufficient medical certification may result in a denial of your FMLA request.

Return this completed form on ____________________ (must be at least 15 days after employee is notified of this requirement).

Employees name:________________________________
First Middle Last

Relationship and name of family member for whom employee will provide care: ________________
Relationship

____
First Middle Last

If family member is your son or daughter, date of birth________________________

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

____

____

________________________ ________________
Employee signature Date

Delete

To be completed by health care provider:

The employee listed above has requested leave under the FMLA to care for your patient. Answer, fully and completely, all applicable parts below. Several questions seek a response as to the frequency or duration of a condition, treatment, etc. Your answer should be the 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 coverage. Limit your responses to the condition for which the patient needs leave. Extra space is provided, should you need it. Please be sure to sign the form on the last page.

Providers's name and business address:____

____

Type of practice/medical specialty:____

Telephone: (______)________________________________ Fax:(______)_________________________

Medical Facts

1. Approximate date condition commenced:____

   Probable duration of condition:____

   Was the patient admitted for an overnight stay in a hospital, hospice or residential medical care facility?
   □ Yes □ No If yes, dates of admission: ______________________________________

   Dates(s) you treated the patient for condition ______________________________________

   Was medication, other than over-the-counter medication, prescribed? □ Yes □ No

   Will the patient need to have treatment visits at least twice per year due to the condition?
   □ Yes □ No

   Was the patient referred to other health care provider(s) for evaluation or treatment (e.g., physical therapist)?
   □ Yes □ No

   If yes, state the nature of such treatments and expected duration of treatment:

   ____

   ____

2. Is the medical condition pregnancy? □ Yes □ No

   If yes, expected delivery date:________________________

Delete

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):

____

____

Amount of leave needed

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

1. Will the patient be incapacitated for a single continuous period of time, including any time for treatment and recovery? □ Yes □ No

   If yes, estimate the beginning and ending dates for the period of incapacity:______________________________

   ____

   During this time, will the patient need care? □ Yes □ No

   Explain the care needed by the patient and why such care is medically necessary:

   ____

   ____

   ____

2. Will the patient require follow-up treatments, including any time for recovery? □ Yes □ No

   Estimate treatment schedule, if any, including the dates of any scheduled appointments and the time required for each appointment, including any recovery period:

   ____

   Explain the care needed by the patient, and why such care is medically necessary: ________________________

   ____

   ____

3. Will the patient require care on an intermittent or reduced schedule basis, including any time for recovery? □ Yes □ No

   Estimate the hours the patient needs care on an intermittent basis, if any:

   ___________ hour(s) per day; ________ days per week from _______________ through ____________________

Delete

Explain the care needed by the patient, and why such care is medically necessary: ________________________

____

____

4. Will the condition cause episodic flare-ups periodically preventing the patient from participating in normal daily activities? □ Yes □ No

Based upon the patient's medical history and your knowledge of the medical condition, estimate the frequency of flare-ups and the duration of related incapacity that the patient may have over the next six months (e.g., one episode every three months lasting one to two days):

Frequency:____________times per _____________week(s) _________ month(s)

Duration: _____________hours or ______________day(s) per episode

Does the patient need care during these flare-ups? □ Yes □ No

Explain the care needed by the patient, and why such care is medically necessary ________________________

____

____

Additional Information – Identify the question number with your additional answer:

____

____

____

____

____

____

____ ____________________________________
Signature of health care provider Date

Approved by President's Council: May 22, 2012
(Date)

Delete

Clackamas Community College

Code: **GCBDA/GDBDA-AR(3)(C)**
Revised/Reviewed: 6/20/12

Military Family Leave

Certification of Qualifying Exigency for Military Family Leave

Section 1: To be completed by the College:

The Family Medical Leave Act (FMLA) and the Oregon Military Family Leave Act (OMFLA) provides that a college may require an employee seeking FMLA or OMFLA leave due to a qualifying exigency or due to notification of impending call to active duty or deployment to submit a certification. Employees may not be asked to provide more information than allowed under the FMLA or OMFLA regulations.

College: ____

College or designee information: ____

Section 2: To be completed by the employee:

Complete the information below fully and completely. The FMLA or OMFLA permits the College to require that you submit a timely, complete and sufficient certification to support a request for FMLA or OMFLA leave due to a qualifying exigency or due to notification of impending call to active duty or deployment. Several questions in this section seek a response as to the frequency or duration of the qualifying exigency. Be as specific as you can; terms such as "lifetime," "unknown" or "indeterminate" may not be sufficient to determine FMLA or OMFLA coverage. Your response is required to obtain a benefit. While you are not required to provide this information, failure to do so may result in a denial of your request for qualifying leave. The College must give you at least 15 calendar days to return this form to the College.

Employee's name: ____

First Middle Last

Name of covered military member on active duty or call to active duty status in support of a contingency operation:

____

First Middle Last

Relationship of covered military member to you: ____

Period of covered military member's active duty: ____

A complete and sufficient certification to support a request for FMLA leave due to a qualifying exigency includes written documentation confirming a covered military member's active duty or call to active duty status in support of a contingency operation. Please check one of the following:

- □ A copy of the covered military member's active duty orders is attached.
- □ Other documentation from the military certifying that the covered military member is on active duty (or has been notified of an impending call to active duty) in support of a contingency operation is attached.
- □ I have previously provided the College with sufficient written documentation confirming the covered military member's active duty or call to active duty status in support of a contingency operation.

Delete

Part A: Qualifying reason for leave

1. Describe the reason you are requesting qualifying leave due to a qualifying exigency (including the specific reason you are requesting leave):

____

____

____

2. Describe the reason you are requesting OMFLA (include specific reason below):

____

____

____

3. A complete and sufficient certification to support a request for qualifying leave due to a qualifying exigency includes any available written documentation which supports the need for leave; such documentation may include a copy of a meeting announcement for information briefings sponsored by the military, a document confirming an appointment with a counselor or school official, or a copy of a bill for services for the handling of legal or financial affairs. Available written documentation supporting this request for leave is attached.
□ Yes □ No □ None available

Part B: Amount of leave needed

1. Approximate date exigency/deployment commenced or will commence ________________________

   Probably duration of exigency ____

2. Will you need to be absent from work for a single continuous period of time due to the qualifying exigency/deployment? □ Yes □ No
   If yes, estimate the beginning and ending dates for the period of absence ________________________

3. Will you need to be absent from work periodically to address this qualifying exigency/deployment?
   □ Yes □ No

   If yes, estimate the schedule of leave, including the dates of any scheduled meetings or appointments:

____

____

Delete

4. Estimate the frequency and duration of each appointment, meeting or leave event, including any travel time (i.e. One deployment-related meeting every month lasting four hours) (FMLA only):

   Frequency: ______ times per _____________ week(s) ________ month(s)

   Duration: _____________ hours or ______________ day(s) per event

Part C: Third party certification

If leave is requested to meet with a third party (such as to arrange for childcare, to attend counseling, to attend meetings with school or childcare providers, to make financial or legal arrangements, to act as the covered military member's representative before a federal, state or local agency for purposes of obtaining, arranging or appealing military service benefits, or to attend any event sponsored by the military or military service organizations), a complete and sufficient certification includes the name, address and appropriate contact information of the individual or entity with whom you are meeting (i.e. either the telephone or fax number or email address of the individual or entity). This information may be used by the College to verify that the information contained on this form is accurate. (FMLA only)

Name of individual ____ Title ____________________________

Organization ____

Address ____

Telephone (   ) ________________________________ Fax (   ) ________________________________

Email ____

Describe nature of meeting ____

____

____

____

____

____

Part D: Employee Signature

I certify that the information I provided above is true and correct. For OMFLA purposes notice must be given by the employee within five business days of receiving official notice.

____ __________________________________

Signature of employee Date

Approved by President's Council: May 22, 2012
(Date)

Delete

Clackamas Community College

Code: **GCBDA/GDBDA-AR(3)(D)**
Revised/Reviewed: 6/20/12

Military Family Leave

Certification for Serious Injury or Illness of Covered Servicemember for Military Family Leave

Notice and instructions to the College:

The Family Medical Leave Act (FMLA) provides that a college may require an employee seeking FMLA leave due to a serious injury or illness of a covered servicemember to submit a certification providing sufficient facts to support the request for leave. Employees may not be asked to provide more information than allowed under the FMLA regulations. The College will maintain records and documents relating to medical certification, recertifications or medical histories of employees or employees' family member, created for FMLA purposes, as confidential medical records in separate files from personnel files and in accordance with 29 C.F.R. § 1630.14(c)(1), if the Americans with Disabilities Act applies.

Section 1

Part A: Employee information

Complete the employee and covered servicemember information below before giving this form to your family member or his/her medical provider.

____

College name and address

Name of employee requesting leave to care for covered servicemember:

____

First Middle Last

Name of covered servicemember for whom employee is requesting leave to care:

____

First Middle Last

Relationship of employee to covered servicemember requesting leave to care:

□ Spouse □ Parent □ Son □ Daughter □ Next of kin

Part B: Covered servicemember information

1. Is the covered servicemember a current member of the regular armed forces, the National Guard or Reserves, or a veteran? □ Yes □ No

   If a current servicemember, please provide the covered servicemember's military branch, rank and unit currently assigned to:

   ____

   ____

Delete

If a veteran, when was the date of discharge? ______________________________

Is the covered servicemember assigned to a military medical treatment facility as an outpatient or to a unit established for the purpose of providing command and control of members of the Armed Forces receiving medical care as outpatients (such as medical hold or warrior transition unit)? □ Yes □ No
If yes, provide the name of the medical facility or unit:

____

2. Is the covered servicemember on the Temporary Disability Retired List (TDRL)? □ Yes □ No

Part C: Care to be provided to the covered servicemember

Describe the care to be provided to the covered servicemember and an estimate of the leave needed to provide the care: ______________________________

____

Section 2:

To be completed by United States Department of Defense (DOD) health care provider or a health care provider who is either: 1) A United States Department of Veterans Affairs (VA) health care provider; 2) A DOD TRICARE network authorized private health care provider; or 3) A DOD non-network TRICARE authorized private health care provider.

If you are unable to make certain of the military-related determinations contained below in Part B, you are permitted to rely upon determinations from an authorized DOD representative (such as a DOD recovery care coordinator). Please ensure that Section 1 above has been completed before completing this section. Please be sure to sign the form on the last page.

Part A: Health care provider information

Health care provider's name and business address:

____

____

Type of practice/Medical speciality: ______________________________

Please state whether you are either: 1) DD health care provider; 2) A VA health care provider; 3) A DOD TRICARE network authorized private health care provider; 4) A DOD non-network TRICARE authorized private care provider: ______________________________

Telephone (______)________________ Fax (______)________________ Email ____________________

Part B: Medical status

1. Covered servicemember's medical condition is classified as (check one of the appropriate boxes):

□ (VSI) Very Seriously Ill/Injured – Illness/Injury is of such a severity that life is imminently endangered. Family members are requested at the bedside immediately. (Please note this is an internal DOD casualty assistance designation used by DOD healthcare providers.)

Delete

- □ (SI) Seriously Ill/Injured – Illness/Injury is of such severity that there is cause for immediate concern, but there is no imminent danger to life. Family members are requested at bedside. (Please note this is an internal DOD casualty assistance designation used by DOD healthcare providers.)
- □ Other Ill/Injured – A serious injury or illness that may render the servicemember medically unfit to perform the duties of the member's office, grade, rank or rating.
- □ None of the above. (Note to employee: If this box is checked, you may still be eligible to take leave to care for a covered family member with a "serious health condition". If such leave is requested, you may be required to complete the form *Certification of Health Care Provider for Family Member's Serious Health Condition.*)

2. Was the condition for which the covered servicemember is being treated incurred in the line of duty on active duty in the armed force? □ Yes □ No

   If no, did the condition exist before the beginning of active duty and aggravated by service in the line of duty while on active duty? □ Yes □ No

3. Appropriate date condition commenced:______________________________

4. Probable duration of condition and/or need for care:______________________________

5. Is the covered servicemember undergoing medical treatment, recuperation or therapy? □ Yes □ No

   If yes, please describe medical treatment, recuperation or therapy:

   ____

   ____

Part C: Covered servicemember's need for care by family member

1. Will the covered servicemember need care for a single continuous period of time, including any time for treatment and recovery? □ Yes □ No
   If yes, estimate the beginning and ending dates for this period of time ______________________________

2. Will the covered servicemember require periodic follow-up treatment appointments? □ Yes □ No
   If yes, estimate the treatment schedule: ______________________________

3. Is there a medical necessity for the servicemember to have periodic care for these follow-up treatment appointment? □ Yes □ No

4. Is there a medical necessity for the covered servicemember to have periodic care for other than scheduled follow-up treatment appointments (e.g. episodic flare-ups of medical conditions)? □ Yes □ No
   If yes, estimate the frequency and duration of the periodic care.

   ____

______________________________ ______________________________
Signature of health care provider Date

Approved by President's Council: May 22, 2012
(Date)

Delete

Clackamas Community College

Code: GCBDA/GDBDA-AR(4)
Revised/Reviewed: 6/20/12; 9/03/13; 7/30/14

Delete

FMLA/OFLA Eligibility Notice to Employee

DATE: ______________________________

TO: ______________________________
(Employee's name)

FROM: ______________________________
(Name of appropriate employer representative)

SUBJECT: Request for FMLA and/or OFLA Leave

On __(date)__________you notified us of your need to take family/medical leave due to:

1. _____ The birth of your child, or the placement of a child with you for adoption or foster care;

2. _____ A serious health condition that makes you unable to perform the essential functions of your job;

3. _____ A serious health condition of your G spouse, G same-sex domestic partner (OFLA leave only), G child[1] (including the biological, grandchild, adopted or foster child or stepchild of an employee, child of same-sex domestic partner or a child with whom the employee is or was in a relationship of "in loco parentis"), G parent (biological parent of an employee or an individual who stood "in loco parentis" to an employee when the employee was a child), G grandparent (OFLA leave only), G parent-in-law (OFLA leave only), G parent of employee's same-sex domestic partner (OFLA leave only), G custodial parent, G noncustodial parent, G adoptive parent, G foster parent for which you are needed to provide care;

4. _____ An illness or injury to your child which requires home care but is not a serious health condition (OFLA leave only);

5. _____ A qualifying exigency arising from a spouse, son, daughter, or parent in the Armed Forces on covered active duty, or in the National Guard or Reserves on covered active duty (FMLA only);

[1]For FMLA, the age of the son or daughter is not relevant in determining a parent's entitlement to FMLA leave.

Delete

6. _____ Your spouse or domestic partner has been notified of an impending call to active duty, has been ordered to active duty, or has been deployed or on leave from deployment (OMFLA only);

7. _____ A serious illness or injury, incurred in the line of duty, of a covered service member who is your spouse, son, daughter, parent or next of kin;

8. _____ For the death of a family member (OFLA only).

You notified us that you need this leave beginning on ___(date)___and that you expect leave to continue until on or about ___(date)___. The FMLA requires that you notify the College as soon as possible if dates of scheduled leave changes or are extended, or were initially unknown.

Except as explained below, you have a right under the FMLA and/or OFLA for up to 12 workweeks of unpaid leave in a 12-month period for the reasons listed above.[2] The College will use the calendar year. FMLA leave and OFLA leave generally run concurrently. In order to care for an injured service member, you are entitled to up to 26 weeks of leave in a single 12-month period to care for a qualifying service member.

Also, your health benefits under FMLA must be maintained during any period of unpaid leave under the same conditions as if you continued to work. You must be reinstated to the same or in some cases, under state or federal law, to an equivalent job with the same pay, benefits and terms and conditions of employment on your return from leave. The College is not required to maintain benefits during OFLA unless provided otherwise by Board policy or collective bargaining agreement; however, all such benefits will be restored in full upon your return to the College.

If you do not return to work following FMLA and/or OFLA leave for a reason other than: (1) the continuation, recurrence or onset of a serious health condition which would entitle you to FMLA and/or OFLA; or (2) other circumstances beyond your control, you may be required to reimburse the College for health insurance premiums paid on your behalf during your FMLA/OFLA leave.

This is to inform you that (check appropriate boxes, explain where indicated):

1. You are G eligible G not eligible for leave under the G FMLA, G OFLA or G both.

2. The requested leave may be counted against your annual G FMLA leave entitlement, G OFLA, G both.

3. You G will G will not be required to furnish medical certification of a serious health condition. If required, you must furnish certification by _(date)__ (must be at least 15 days after you are notified of this requirement).

---

[2]Oregon Military Family Leave allows for 14 days of leave per deployment.

4. You will be required to use you G sick, G vacation and/or G personal leave during your medical leave absence. This means that you will receive your paid leave and the leave will also be considered protected and counted against your entitlement.

5a. If you normally pay a portion of the premiums for your health insurance, these payments will continue during the period of FMLA leave. Arrangements for payment have been discussed with you and it is agreed that you will make premium payments as follows: (Set forth dates, e.g., the 10th of each month, or pay periods, etc. that specifically cover the agreement with the employee.)

5b. The College is not required to maintain benefits while an employee is on OFLA leave unless otherwise provided for by Board policy and/or collective bargaining agreements; however, all benefits must be restored in full upon the employee's return to work. The College G will G will not maintain benefits during OFLA leave.

5c. If the College pays any part of your share of health or other insurance benefits while on OFLA or FMLA leave the College may deduct up to 10 percent of your gross pay each pay period after your return to work until the amount is repaid (OFLA leave only).

5d. You have a minimum 30-day grace period in which to make premium payments. If payment is not timely made, your group health insurance may be cancelled. We will notify you in writing at least 15 days before the date that your health coverage will lapse. At our option, we may also pay your share of the premiums during FMLA/OFLA leave as provided by Board policy and/or collective bargaining agreement, and recover these payments from you upon your return to work. We G will G will not pay your share of health insurance premiums while you are on FMLA and/or OFLA leave.

5e. We G will G will not do the same with other benefits (e.g., life insurance, disability insurance, etc.) while you are on FMLA and/or OFLA leave. If we do pay your premiums for other benefits, when you return from leave you G will G will not be expected to reimburse us for the payments made on your behalf.

5f. Except as noted above, in the event you do not return to work for the College after your FMLA and/or, OFLA leave and the College has paid your share of benefit premiums, you G will G will not be responsible for reimbursing the College the amount paid on your behalf, with the exceptions noted in Section 104 (c)(2)(B) of the FMLA.

6. G You will be required to present a fitness-for-duty certificate prior to being restored to employment following leave for your own serious health condition. If such certification is required but not received, your return to work may be delayed until the certification is provided. A list of essential functions for your position is attached. The fitness-for-duty certification must address your ability to perform these functions.

G You will not be required to present a fitness-for-duty certificate prior to being restored to employment following leave for your own serious health condition. If such certification is required but not received, your return to work may be delayed until the certification is provided.

Delete

7a. You G are G are not a "key employee" as described in Section 825.218 of the FMLA regulations. If you are a "key employee," restoration to employment may be denied following FMLA leave on the grounds that such restoration will cause substantial and grievous economic injury to us. (FMLA leave only.)

7b. We G have G have not determined that restoring you to employment at the conclusion of FMLA leave will cause substantial and grievous economic harm to us. (FMLA leave only.) (Explain (a) and/or (b) below.)

8. While on FMLA and/or OFLA leave, you G will G will not be required to furnish us with periodic reports every (indicate interval of periodic reports, as appropriate for the particular leave situation) of your status and intent to return to work. If the circumstances of your leave change and you are able to return to work earlier than the date indicated on this form, you G will G will not be required to notify us at least two workdays prior to the date you intend to report for work.

9. You G will G will not be required to furnish recertification relating to a serious health condition. (FMLA leave only.) (Explain below, if necessary, including the interval between certifications as prescribed in Section 825.308 of the FMLA regulations.)

10. You are notified that all leave taken for the purposes of the death of a family member, counts toward the total period of authorized OFLA leave.

Delete

Approved by President's Council: July 30, 2014
(Date)

Delete

Sample Designation Letter to Employee - FMLA/OFLA Leave

The following is a sample cover letter to an employee notifying the employee that the employer is treating a request for leave as a request for FMLA and/or OFLA leave (either paid or unpaid) that will reduce the employee's FMLA and/or OFLA leave entitlement. This letter, along with the Designation Notice form GCBDA/GDBDA-AR(6), FMLA/OFLA or GCBDA/GDBDA-AR(4), OFLA only eligible, should be mailed to the employee within five working days after receiving enough information to determine whether the leave qualifies under FMLA or OFLA.

Dear Employee:

On ____(date)______ you advised the College that you were requesting a leave under the Family and Medical Leave Act (FMLA) and/or Oregon Family Leave Act (OFLA). Under our policy, leaves of absence that qualify for family and medical leave under federal law (FMLA) run concurrently with other types of leave such as sick leave, vacation leave, short-term disability leave, OFLA and leave for a workers' compensation injury or illness. Leaves of absence that qualify for family and medical leave under state law (OFLA) can run concurrently with other types of leave such as sick leave, vacation leave, short-term disability leave but cannot run concurrently with leave for workers' compensatory injury or illness.

We understand the purpose of your requested leave qualifies as family medical leave under state and/or federal law. Accordingly, this letter is to notify you that the leave will be counted against your annual family and medical leave entitlement. Also attached is a form entitled Designation Notice which contains other information for you regarding federal and state family medical leave rights.

Sincerely,

Dean of Human Resources

Enclosure (FMLA and/or OFLA Designation Notice form)

Approved by President's Council: May 22, 2012
(Date)

Delete

Clackamas Community College

Code: **GCBDA/GDBDA-AR(6)**
Revised/Reviewed: 6/20/12

Designation Notice – FMLA/OFLA

Delete

Leave covered under the Family and Medical Leave Act (FMLA) and/or Oregon Family Leave Act (OFLA) must be designated as FMLA and/or OFLA-protected and the College must inform the employee of the amount of leave that will be counted against the employee's FMLA and/or OFLA leave entitlement. In order to determine whether leave is covered under the FMLA and/or OFLA, the College may request that the leave be supported by a certification. If the certification is incomplete or insufficient, the employer must state in writing what additional information is necessary to make the certification complete and sufficient.

Employee ____

Date _________________________

We have reviewed your request for leave under the FMLA and/or OFLA and any supporting documentation that you have provided. We received your most recent information on: ________________ and decided: ____

□ Your request is approved for FMLA. All leave taken for this reason will be designated as FMLA leave.

□ Your request is approved for FMLA and OFLA. This designation of leave will run concurrently.

□ Your request is approved for OFLA. All leave taken for this reason will be designated as OFLA leave.

The FMLA and/or OFLA requires that you notify us as soon as practicable if dates of scheduled leave change or are extended, or were initially unknown. Based on the information you have provided to date, we are providing the following information about the amount of time that will be counted against your entitlement:

□ Provided there is no deviation from your anticipated leave schedule, the following number of hours, days or weeks will be counted against your leave entitlement: ________________________________

□ Because the leave you will need will be rescheduled, it is not possible to provide the hours, days or weeks that will be counted against your FMLA and/or OFLA entitlement at this time. You have the right request this information once in a 30-day period (if leave was taken in the 30 day period).

Please be advised (check if applicable):

□ You have requested to use paid leave during your FMLA and/or OFLA leave. Any paid leave taken for this reason will count against your FMLA and/or OFLA leave entitlement.

□ We are requiring you to substitute or use paid leave during your FMLA and/or OFLA leave.

□ You will be required to present a fitness-for-duty certificate to be restored to employment. If such certification is not timely received, your return to work may be delayed until certification is provided. A list of the essential functions of your position □ is □ is not attached. If attached, the fitness-for-duty certifications must address your ability to perform these functions.

____

□ Additional information is needed to determine if your FMLA and/or OFLA leave request can be approved.

□ The certification you have provided is not complete and sufficient to determine whether the FMLA and/or OFLA applies to your leave procedures. You must provide the following information no later than _________________________________(at least 15 calendar days), unless it is not practicable under the particular circumstances despite your diligent good faith efforts, or your leave may be denied. The information needed to make the certification complete and sufficient is:

____

____

□ We are exercising our right to have you obtain a second or third opinion medical certification at our expense, and we will provide further details at a later time.

****

□ Your FMLA leave request is NOT APPROVED.

□ The FMLA does not apply to your leave request.

□ You have exhausted your FMLA leave entitlement in the applicable 12-month period. (Note: Federal Military Family Leave is on a separate 12-month period.)

□ Your OFLA leave request is NOT APPROVED.

□ The OFLA does not apply to your leave request.

□ You have exhausted your OFLA leave entitlement in the applicable 12-month period.

Approved by President's Council: May 22, 2012
(Date)

Delete

Clackamas Community College

Code: **GCBDA/GDBDA-AR(7)**
Revised/Reviewed: 6/20/12

Fitness-for-Duty Certification

To: ____ Date: ____________________________

From: ____

Subject: Fitness-for-Duty Certification

Family and Medical Leave for your own serious health condition ends on (date) _____________________. Prior to returning to work you must provide a Fitness-for-Duty Certification verifying whether you are able to return to work, if you have any job-related restrictions and the duration of any restrictions. Please take this Fitness-for-Duty Certification to your healthcare provider for completion. The College will use this Fitness-for-Duty Certification to determine if you are able to return to work after your leave.

Return the completed Fitness-for-Duty Certification to the College prior to the end of your Family and Medical Leave or by (date) _________________________.

Fitness-for-Duty Certification

Health Care Provider Completes this Section

Instructions: Please complete all sections in order for the College to determine if the employee is able to return to duty. The employee's position description or a list of essential duties (College specifies which) is attached to this form.

1. The employee is able to return to work full-time without restrictions: □ Yes □ No

   a. If yes, list the effective date ____________________.

   b. If no, complete the following:

      (1) The employee will be able to return to work with no limitation on (date) _____________.

      (2) I certify that from (date) ______________________ to (date) ____________________ the above named employee will be:

         (a) □ Unable to perform the physical requirements of their work; or

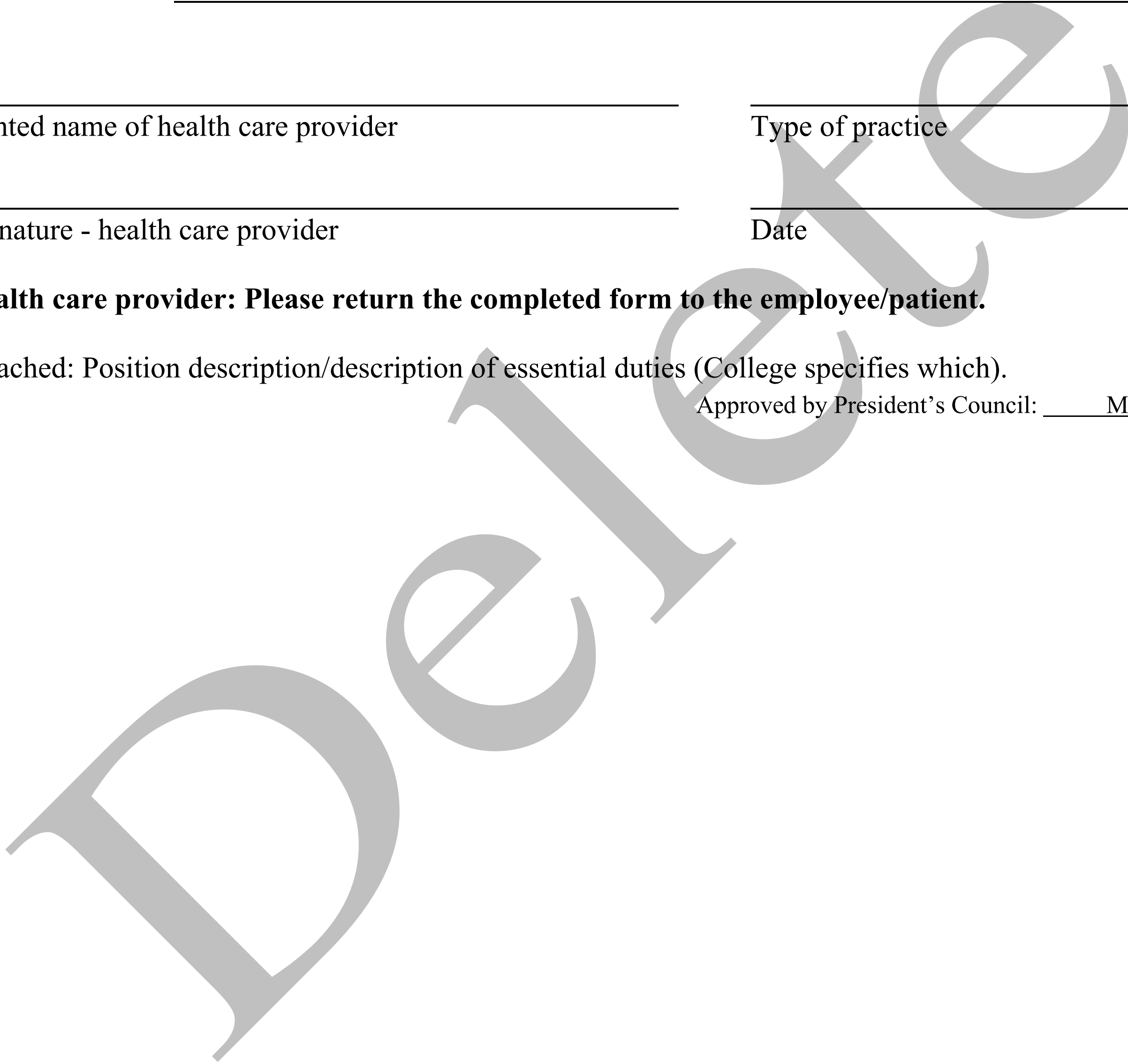
         (b) □ Is medically incapacitated: □ Totally □ Partially**

Delete

**If partially medically incapacitated, complete the following:

(c) Number of hours per day employee is able to work ________________________.
(d) Number of days per week employee is able to work ________________________.

(3) List any restrictions on the employee's work: ___________________________________
____
____
____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______________________________	______________________
Printed name of health care provider	Type of practice
______________________________	______________________
Signature - health care provider	Date

Health care provider: Please return the completed form to the employee/patient.

Attached: Position description/description of essential duties (College specifies which).

Approved by President's Council: May 22, 2012
(Date)

Code: GCBDD/GDBDD
Adopted: 6/27/18

Clackamas Community College

Sick Time

"Employee" means an individual who is employed by the community college and who is paid on an hourly, stipend or salary basis, and for whom withholding is required under Oregon Revised Statute (ORS) 316.162-316.221. The definition does not include volunteers or independent contractors.

Employees qualify to begin earning and accruing sick time on the first day of employment with the community college.

END OF POLICY

Legal Reference(s):

ORS 342.545
ORS 342.610
ORS 653.601 to -653.661
ORS 659A.150 to -659A.186

Americans with Disabilities Act of 1990, 42 U.S.C. §§ 12101-12213 (2012); 29 C.F.R. Part 1630 (2016); 28 C.F.R. Part 35 (2016).
Family and Medical Leave Act of 1993, 29 U.S.C. §§ 2601-2654 (2012); Family and Medical Leave Act of 1993, 29 C.F.R. Part 825 (2016).
Americans with Disabilities Act Amendments Act of 2008.

Cross Reference(s):

ACA - Americans with Disabilities Act
GBDA - Mother Friendly Workplace
GCBDA/GDBDA - Family Medical Leave

Delete

Clackamas Community College

Code: GCQBA
Adopted: 12/14/11

Copyrights and Patents

The Board asserts the College's proprietary rights to publications, instructional materials and other devices prepared by College employees during their paid work time. The Board also recognizes the importance of encouraging its professional staff to engage in professional writing, research and other creative endeavors. Publications, articles, materials, models and other items produced by College personnel for College use with College time, money and facilities as part of an employee's job responsibilities remain the property of the College.

The College will apply for copyrights and patents when deemed appropriate by the President. Employees will be expected to cooperate in the College's efforts.

In the event that an employee produces items described above partly on his/her own time and partly on College time, the College reserves the right to claim full ownership. The employee, however, may petition the College for assignment of copyright or patent rights. Employees will not attempt to copyright or patent such items without the knowledge and consent of the President.

END OF POLICY

Legal Reference(s):

ORS 332.745

Copyrights, 17 U.S.C. §§ 101- 1332; 19 C.F.R. Part 133.
Patents, 35 U.S.C. §§ 1-376.

Cross Reference(s):

EGAAA - Reproduction of All Copyrighted Materials

Delete