Oklahoma Department of Corrections Paid Leave Request Form

To Be Completed By The Employee:

Name (PRINT) Regular Days Off			State Employee ID# Regular Scheduled Work Hours		Job Title Facility/Unit		
							Арр
Тур	e of Leave Requested	d (Check √ one):		Ending:	Time	Date	
	Ciale Lagues Lag		bla ta waylı basayısı af air	alemana imierme	Time	Date	
	dental or optical designation as	examination or tre family and medic	ble to work because of side eatment. I understand that all leave and that I am as requested by my supen	t my request for required to p	or sick leave w	ill be reviewed for	
	illness or injury, disaster (unfores leave balance, r	Enforced Leave: I certify that I must care for a member of my immediate family or household because or illness or injury, or there has been a death in my immediate family or household, or I have had a personal disaster (unforeseen, catastrophic event). I understand that enforced leave is charged to my accrued sick leave balance, may not exceed 10 working days in any calendar year, and that I am required to produce documentation of the need for enforced leave as requested by my supervisor.					
	organization of v	Organizational Leave : I certify that this request is for the purpose of attending a meeting of a job related organization of which I am a member and that there will be no lobbying activities. I understand that such leave is limited to 3 days per year. Meeting or conference agenda is attached.					
		Military Leave : (limited to 30 working days per federal fiscal year, October 1 through September 30 Orders are attached or will be provided immediately upon my return to work.					
	Jury/Court Leav	ve : Documentation	is attached.				
	Personal time of	Personal Time Off (paid leave not covered by any of the above leave programs): Personal time off from work will be charged to Holiday or Compensatory time (exempt employees only) of Administrative (hazardous weather) Leave or Annual leave as approved by the supervisor					
	ime or leave.	e useu to aujust	hours within the FLSA	work period ii	i lieu oi charg	ing the absence	
			with any laws or rules gov absence exceeds accrued			erstand that leave	
Signature of Employee					Date		
To Be Comp	leted By the Superv						
You	r request has been:	□Approved □Denied/Reaso	n for denial of organizatio	nal le ave:			
This request for leave has determination made:		☐ Leave has be toward the annu-	for designation as family been designated as FM al 12 week entitlement t been designated as FML	LA until	, ,	and the following will be counted	
		☐ Leave has be toward the annual Leave has be toward the annual	d for designation as militioned designated as MFN al 12 week exigency entitle on designated as MFN al 26 week caregiver entit the been designated as MFN al 26 week caregiver entit the second of the	ILA until ement ILA until lement	and Date		
also certifie	s that if the leave	has been design	bove information and it ated as FMLA &/or MF ee" (FMLA)/(MFMLA) – \$	MLA then I h	nave provided	I the requesting	
Signature of Supervisor					Date		
						Attachmant A	
Distribution:	Original to Perso	nnel File	Copy to Employee			Attachment A OP-110355	

OP-110355 Side 1 (R 10/18)

Employer's Notice to Employee (FMLA)

- 1. All leave designated as family and medical leave (FMLA) will be counted towards your annual 12 week entitlement.
- 2. Family and medical leave may be paid or unpaid and you may elect to use accrued sick or annual leave, or compensatory time (exempt employees only) in lieu of unpaid leave. Your failure to specify that a leave request is for family and medical leave does not prevent the department from designating leave as family and medical leave when appropriate.
- 3. If medical certification is required or has been requested:

Failure to provide complete medical certification may result in denial or delay of requested leave

Additional medical certification will be required not more often than every 30 days or when you request an extension of intermittent leave or leave that was originally approved for more than 30 days. The department may also require recertification if the circumstances described in your current certification change significantly or we receive information that casts doubt on your stated reason for absence.

4. You may be required to provide the department with certification that you are fit for duty prior to returning to work for any absence that was taken for your own serious illness. This requirement will not apply when leave is taken on an intermittent basis.

Employer's Notice to Employee (MFMLA)

- 1. All leave designated as military family leave (MFMLA) for a qualifying exigency will be counted towards your annual 12 week entitlement. This entitlement in combination with any use of family and medical leave (FMLA) cannot exceed 12 work weeks (480 hours) total during a 12 month period.
- 2. All leave designated as military family leave (MFMLA) to care for a covered military service member will be counted towards your annual 26 week entitlement. This entitlement in combination with any use of family and medical leave (FMLA) and/or any use of military family leave (MFLMA) for a qualifying exigency cannot exceed 26 work weeks (1040 hours) total during a single 12 month period. However, this will not limit the availability of leave under standard FMLA or MFMLA for a qualifying exigency during any other 12 month period.
- 3. Military family leave may be paid or unpaid and you may elect to use accrued sick or annual leave, or compensatory time (exempt employees only) in lieu of unpaid leave.
- 4. If the military service member medical certification is required or has been requested, failure to provide a completed military service member medical certification may result in denial or delay of requested leave.
- 5. The department may require you to provide confirmation that an instance of intermittent leave is related to the military family leave event for which the MFMLA intermittent leave was originally granted.