Oklahoma Department of Corrections
Family and Medical Leave Request Form (Side 1)
Employer’s Notice to Employee (Side 2)

To Be Completed By the Employee:

______________________________ __________________________    _________________________
Name of Employee (PRINT)  State Employee ID#                   Facility/Unit

I am requesting family and medical leave pursuant to Merit Rule 530:10-15-45, the Family and Medical Leave Act of 1993, and OP-110355 entitled “Leave Programs” for the following reason: (check √ one)

☐ a serious health condition (medical certification is required and attached unless waived by the facility/unit head)

☐ to care for my spouse, son, daughter, or parent (name and relationship provided below) with a serious health condition (medical certification is required and attached unless waived by the facility/unit head)
Name:________________________________________ Relationship:_______________________
Describe the care you will provide: ___________________________________________________
________________________________________________________________________________

☐ the placement of a son or daughter for adoption or foster care with me (legal documentation is required and attached unless waived by the facility/unit head)

☐ the birth of my son or daughter, and to provide care for the newborn child

I am electing the following leave option(s) to cover family and medical leave absence: (number the options in the order in which you plan to use. Contact your HRMS if you do not wish to exhaust any balance prior to changing leave programs):
☐ sick ☐ annual ☐ compensatory ☐ leave without pay ☐ donated leave (if approved and balance available)

Anticipated/Actual Date FMLA Begins:  _______________ Ends:  _________________

Is this a request for intermittent leave or a reduced work schedule?       Yes   No
If yes, describe:____________________________________________________________________________

____________________________________                                           ___________________________
Employee Signature                   Date

HRMS Signature: The above referenced employee is eligible for FMLA: Employment with the State for 12 months; worked (including any period of military leave) a minimum of 1,250 hours in the 12 months preceding the date leave commences; has not exhausted the 12 week limit during the 12 months preceding the date leave commences; has leave balances to cover the leave elections.

HRMS Signature __________________________ Date

Supervisor Signature: The request for FMLA is ☐ Approved through __________    ☐ Denied (check reason(s):

☐ employee is not eligible

☐ documentation not submitted or does not support FMLA use

☐ intermittent or reduced schedule for birth or placement of a child will interfere with the operations of the facility/unit

Medical certification has been waived: ☐ Yes ☐ No

Supervisor Signature __________________________ Date

Distribution: Employee Personnel File and copy to Employee
Employer’s Notice To Employee

1. All leave designated as family and medical leave will be counted towards your 12 week entitlement.

2. Family and medical leave may be either paid or unpaid leave and you may elect to use accrued sick leave, annual leave, compensatory time (exempt employees only), or donated leave 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 requested, failure to submit complete medical certification may result in delay or denial of 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 statement change significantly or we receive information that casts doubt on your stated reason for absence.

4. While on any unpaid absence designated as family and medical leave, you are responsible for making premium payments for any insurance for yourself or dependents not covered by the benefit allowance(s). Failure to remit such payments may result in a cancellation of that insurance coverage. If any insurance coverage is cancelled due to your failure to make premium payments, the department will cease making any payments towards that coverage.

Checks or money orders must be made payable to the Employee Benefits Department and are due no later than the 10th day of each month at the following address:

Department of Corrections/Benefits Manager
3400 Martin Luther King Avenue
P.O. Box 11400
Oklahoma City, Oklahoma 73136-0400

The department's Benefits Manager will be sending you information about any premium payments for which you are responsible. This information is also available on your Confirmation of Benefits Statement which lists all insurance in which you and your dependents are enrolled, the premiums, the amounts applied from your benefit allowance(s) and the balance.

5. If you fail to return to work following an unpaid absence during which time the department paid insurance premiums on behalf of yourself or your dependents, you will be liable for reimbursing the department for the premiums that were paid.

6. 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 to when leave is taken on an intermittent basis.

(R 10/20)