APPLICATION - FAMILY OR MEDICAL LEAVE

Return to: **PMB #116, 5331 S Macadam Ave, Suite 258**
Portland, Oregon 97239

In Portland: **(503) 224-0048, ext 1678**
Toll Free: **1-800-547-4457, ext 1678**

Each employee who seeks benefits for Family and Medical Leave must complete all information requested. It is your responsibility to ensure that your employer completes the information directed toward it concerning your leave. It is your responsibility to ensure that the completed application is returned to the Western States Trust Fund. If you or your employer needs additional space to complete a question, please attach an additional sheet of paper.

_____ _____
Full Name - Please Print Social Security Number

_____
Permanent Address

_____ (_____)_____
Date of Birth Telephone

1. Are you a participating employee in the Western States Trust Fund:

   Yes_____ No_____

2. Provide the name, address and telephone number of your current employer:

   _____

   _____

   _____

3. Have you already applied to your employer for family and medical leave?

(Check One) Yes_____ No_____

If your answer to question 3 is yes, answer the following questions:

a) Was your request granted? Yes_____ No_____

b) State the name and job title of the individual who granted or denied your request:

_____

c) If your request for leave was granted, when will it start?

_____

d) Do you intend to return to work for your employer following the family and medical leave?

Yes_____ No_____

4. If your answer to question 3 is no, answer the following question:

a) When do you intend to apply to your employer for family and medical leave?

_____

5. Please state the basis for your application for family and medical leave:
(Check appropriate box)

☐ Birth of a child or placement of a child for adoption or foster care.

☐ To care for a spouse, child or parent with a serious health condition.

☐] Your own serious health condition.

A serious health condition is defined as an illness, injury or impairment, including: (i) inpatient treatment; (ii) absence from work or school for three or more days with continuing treatment by a health care provider; (iii) continued treatment by a health care provider or a condition which is incurable or serious enough to result in three or more days of incapacity; or (iv) parental care.

I certify that the answers to the questions on this application form are true and correct.

_____ _____
Sign Your Name Date

EMPLOYER QUESTIONS

1. Has _____ applied to you for family and
(insert applicant's name)
medical leave? _____ Yes _____ No (check one)

2. If your answer to question 1 is yes, state the period of time the employee will be off work for family and medical leave.

From: _____ To: _____

3. Indicate the total length of time _____
(insert applicant's name)
has worked for your company. _____

(If this employee has worked for your company on several occasions, total all time worked.)

4. Has _____ worked for your company at least
(insert applicant's name)
1,250 hours in the 12-month period of time immediately preceding the family and medical leave?

Yes _____ No _____

5. Please state the reasons(s) or condition(s) that resulted in your company granting

family and medical leave to _____
(insert applicant's name)

_____

_____

I certify that the answers to the questions on this application form are true and correct.

_____ _____
Sign your name Date

_____
Job Title