

## The logo for Deschutes County is a circular emblem. The top half of the circle is blue, representing the sky, with a yellow sun partially obscured by a white mountain peak. Below the mountain is a green forest of evergreen trees. The bottom half of the circle is yellow, representing a river or lake, with a blue wavy line indicating the water's surface. The words "DESCHUTES COUNTY" are written in a semi-circle above the emblem.

[illegible]

# Protected Leave Request Form



**HUMAN  
RESOURCES**

## Health Insurance Premium Payment

Employees who are in Unprotected Leave Without Pay (LWOP) status for more than 40 hours in a pay period may be responsible for paying the full or pro-rated cost of their health insurance premium. If the LWOP is less than 40 hours but the employee does not have sufficient accrued leave or earnings to cover their portion of the premium, they are responsible for paying the employee share of the health insurance premium directly. In the event that this occurs I will pay by:

Check      Catch-up upon return      Drop Coverage (requires proof of other coverage)

## Employee Acknowledgment

By signing below, I acknowledge that:

- I understand that if my leave is for my own or a family member's serious health condition, a completed Health Care Provider Certification must be submitted to Deschutes County within 15 days. Failure to do so may result in delay or denial of leave.
- If applying for Paid Leave Oregon (PLO) benefits, I am responsible for submitting required medical documentation to the state. The County will not provide this on my behalf.
- If I choose to use accrued leave during PLO-approved leave, I may only use it up to my scheduled hours per day.
- If my leave is for my own serious health condition, I must submit a Release to Return to Work form signed by my healthcare provider before resuming duties.
- I am responsible for notifying my supervisor when absences relate to my approved protected leave and will adhere to my department's normal call out procedures.
- I will continue to pay my share of benefit premiums while on leave, unless I elect to discontinue coverage.
- I certify that this leave request is for the purpose(s) stated above and understand that I must comply with County leave procedures, including providing required documentation.

Employee Signature: \_\_\_\_\_ Date: \_\_\_\_\_

## Supervisor Acknowledgment

I have reviewed this leave request and acknowledge the employee's need for time away from their position. I understand that Deschutes County retains full discretion in determining the eligibility and approval of this request.

Supervisor Name: \_\_\_\_\_

Supervisor Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**Return completed form to [Benefits@deschutes.org](mailto:Benefits@deschutes.org)**