City of Portland

Safety Net Temporary Leave Program Leave of Absence Application

(●) New Request ( ) Extension

Employee Information *(Type or Print)*		
Name:		Personnel Number:
Home Address:		
Home Phone:	Personal Email:	
Work Phone:	Bureau/Office:	

Reason for Leave: *(Type or Print)*

Leave Request	
Start date:	End date:

Employee Acknowledgement
• I understand that my leave may be canceled at any time by my bureau and failure to return to work as directed shall be considered a voluntary separation from City service. I understand I will have up to 30 calendar days to return to work following notice by my manager. • I understand that I will not accrue any new paid leave during this period of unpaid leave. • I agree that while on leave, I will continue to pay my share of healthcare insurance premiums, if applicable, unless I elect (in writing) to discontinue coverage. My portion of medical, dental and vision coverage (calculated through the fiscal year, or earlier if leave ends before plan year) will be deducted from the final paycheck before leave begins and is based on my current elections and rates. If total deductions exceed the amount of my final paycheck, I agree to work with the Benefits Office regarding payment options. If I experience a qualified family status change during the plan year, I agree to notify the Benefits Office (in writing) within 60 days and work to adjust premiums accordingly. If my leave extends into the next fiscal year, I will enter into a new payment arrangement with the Benefits Office based on future elections and rates. It's reasonably expected premiums will be collected within the year in which they occur. I understand employees who opt-out of medical coverage will not receive any opt-out dollars while in a no pay status. If I am enrolled in the Healthcare Flexible Spending Account, I will contact the Benefits Office to discuss continuation options, as there are restrictions due to IRS regulations. Enrollment in the Dependent Care Flexible Spending Account will be canceled on my last regular working day and future deductions will not be taken. My Employee Assistance Plan (EAP) will continue while on the approved leave and there is no employee contribution for this coverage. • I also agree that if I fail to return to work at the end of the leave period, I will reimburse the City for its share of City-provided health benefits during my leave, unless I fail to return to work because of the continuation, recurrence, or onset of my own serious health condition, or by other circumstances beyond my control. • I understand that if I do not return to work on the date indicated above (or another date as specified by me and agreed to by the City), my employment may be terminated by the City as of the date my leave expires.
Employee Signature | Date
Supervisor Approval
Supervisor Name (*Type or print*):
Supervisor Signature | Date

Bureau Director Approval		
Director Name (*Type or print*):		
Director Signature	Date	

Forward copy of completed application to benefits@portlandoregon.gov
Forward copy of completed form to Bureau Timekeeper
File copy in the employee's Bureau File and Official Personnel File