Human Resources

# Request for Family and Medical Leave

Please return the completed certification form to your Family Medical Leave (FML) administrator within 15 calendar days of receipt of this application or the date condition commenced. Failure to provide a complete and sufficient medical certification may result in denial of your FML request.

- Part I is completed by the employee requesting leave.
- Part II is completed by a health care provider only.

**Employee information**

If you meet the eligibility requirements under the federal Family and Medical Leave Act (FMLA):

- You have a right to receive up to 12 weeks unpaid leave in a 12-month period.
- If you currently receive employer-paid health benefits, you will be able to continue your basic insurance coverage during FMLA leave. If you have questions, please contact HR Benefits at **859-257-9519,** option 3.
- For information on FMLA and university policy, please refer to HR Policy 88.0 Family and Medical Leave Act. Policies are available online at **www.uky.edu/hr**.
- Send completed application directly to your FML administrator:
  UK HealthCare: Fax to **859-257-2010**
  UK Campus: Fax to **859-257-1679**

With questions, call your FML administrator: UK HealthCare **859-323-0256**, Campus **859-323-4259**

## PART I: To be completed by employee (please print)

Employee name _____ Department _____

Employee person ID _____

Employee home or primary phone _____ Supervisor _____

Family and Medical Leave is needed to care for (check one):

- ☐ Personal health condition
- ☐ Family member's health condition (indicate relationship)
  - ☐ Parent (not parent-in-law) ☐ Spouse ☐ Child (age: _____)
  - ☐ Sponsored adult dependent ☐ Sponsored child dependent (age: _____)
  - NOTE: If for family member, please complete part IA
- ☐ Newborn or newly placed adoptive/foster child

Regular work hours per week
☐ 40 ☐ 37.5 ☐ 30 ☐ 20
☐ Other: _____

Days per week scheduled to work
☐ Monday-Friday
☐ Other: _____

Work shift
☐ Days ☐ Evening ☐ Night
☐ Other: _____

I am requesting leave
From: _____ To: _____

I am requesting a reduced work schedule
From _____ hours per week to _____ hours per week

I am requesting an intermittent work schedule (please describe in detail):

If you are requesting a reduced or intermittent work schedule because of your own serious health condition, please provide your health care provider with a description of your job tasks. If you need assistance, contact your supervisor.

## PART IA: Leave to care for a family member

Please describe the care you will provide:

| **Employee signature** | **Date** |
|---|---|

## PART II: To be completed by health care provider

Your patient has requested leave under the FMLA. Answer, fully and completely, all applicable parts. Several questions seek a response as to the frequency or duration of a condition, treatment, etc. Your answer should be your best estimate based upon medical knowledge, experience and examination of the patient. Be as specific as you can. Terms such as "lifetime," "unknown" or "indeterminate" may not be sufficient to determine FMLA coverage. Limit your responses to the condition for which the employee is seeking leave. Please be sure to sign the form on page 3.

Employee's name _____ Patient's name _____

Is the patient's health condition a "Serious Health Condition" as defined on page 4? ☐ Yes ☐ No

If yes, date the condition commenced: _____

If patient's condition meets one or more of the serious health condition definitions, please check the applicable categories:

☐ Hospital/inpatient care ☐ Absence plus treatment ☐ Pregnancy ☐ Chronic condition
☐ Permanent or long-term incapacity ☐ Multiple treatments

Is the patient incapacitated? ☐ Yes ☐ No

Estimated duration of condition and/or incapacity: Dates of hospitalization from _____ to _____

**Treatment plan:** Please provide the following information or you may attach a copy of the patient's treatment plan

Dates of treatment/follow-ups _____ Period required for recovery _____

Number of treatments/follow-ups _____ Interval between treatment(s) _____

Will the patient need to have treatment visits at least twice per year due to the condition? ☐ Yes ☐ No

Was medication, other than over-the-counter medication, prescribed? ☐ Yes ☐ No

Was the patient referred to other health care providers for evaluation or treatment (e.g. physical therapy)? ☐ Yes ☐ No

If yes, state the nature of such treatments and expected duration of treatment:

**Employee work schedule:** The employee's regular work schedule is described in Part I of this form. If the employee must be absent from work, please provide the following information:

Specific dates you are recommending employee be off of work: From _____ to _____

Is it necessary for the employee to work a reduced or intermittent work schedule because of the employee's or family member's health condition? ☐ Yes ☐ No

Estimate the hours the employee or family member needs care on an intermittent basis: _____ Hours per day _____ days per week

What is the duration of time that the recommended schedule should be in place? _____

Will the condition cause episodic flare-ups, periodically preventing the employee from performing job functions? ☐ Yes ☐ No

Is it medically necessary for the employee to be absent from work during the flare-ups? ☐ Yes ☐ No

If yes, explain:

**Based upon the patient's medical history and your knowledge of the medical condition, estimate the frequency of flare-ups and the duration of related incapacity that the patient may have over the next 6 months (e.g. 1 episode every 3 months lasting 1-2 days):**

**Frequency: _____ times per ☐ week(s) or ☐ month(s)** **Duration: _____ hours or _____ day(s) per epidode**

For patients who are UK employees with attached job description: Is the patient able to perform all of the essential job functions specified in the job description? ☐ Yes ☐ No

If no, which functions cannot be performed?

If leave is required to care for an employee's family member, please respond to the following:

Does your patient require assistance for basic medical or personal needs, safety or transportation? ☐ Yes ☐ No

Would the employee's presence to provide psychological comfort be beneficial to the patient or assist in the patient's recovery? ☐ Yes ☐ No

Describe other relevant medical facts, if any, related to the condition for which the employee seeks leave (such medical facts may include symptoms, diagnosis, or any regimen of continuing treatment such as the use of specialized equipment):

Health care provider information (please complete or attach business card with information)

Name (please print) _____ Specialty _____

Business address _____

Phone _____

| **Health care provider signature** | **Date** |
|---|---|

## Serious health condition definitions in accordance with FMLA

**Hospital/inpatient care** – Inpatient care (i.e. an overnight stay) in a hospital, hospice, or residential medical care facility, including any period of incapacity* or subsequent treatment in connection to such inpatient care.

**Absences for work plus treatment** – A period of incapacity* of more than three consecutive calendar days (including any subsequent treatment or period of incapacity* relating to the same condition) that also involves:

1. Treatment** two or more times by a health care provider, by a nurse or physician's assistant under direct supervision of a health care provider, or by a provider of health care services (e.g. physical therapist) under orders of, or on referral by, a health care provider; or
2. Treatment ** by a health care provider on at least one occasion which results in a regimen of continuing treatment*** under the supervision of the health care provider.
3. The treatments must be within 30 days of when the condition starts. The first visit must be within 7 days.

**Pregnancy** – Any period of incapacity due to pregnancy or for prenatal care.

**Chronic conditions requiring treatments** – A chronic condition which:

1. Requires periodic visits of at least 2 annually for treatment by a health care provider, or by a nurse or physician's assistant under direct supervision of a health care provider;
2. Continues over an extended period of time (including recurring episodes of a single underlying condition); and
3. May cause episodic rather than a continuing period of incapacity* (e.g. asthma, diabetes, epilepsy, etc.).

**Permanent/long-term conditions requiring supervision** – A period of incapacity* which is permanent or long-term due to a condition for which treatment may not be effective. The employee or family member must be under the continuing supervision of, but need not be receiving active treatment by a health care provider. Examples include Alzheimer's, a severe stroke, or the terminal stages of a disease.

**Multiple treatments (non-chronic conditions)** – Any period of absence to receive multiple treatments (including any period of recovery there from) by a health care provider or by a provider of health care services under orders of, or on referral by a health care provider, either for restorative surgery after an accident or an injury, or for a condition that would likely result in a period of incapacity* of more than three consecutive calendar days in absence of medical intervention or treatment, such as cancer (chemotherapy, radiation, etc.), severe arthritis (physical therapy), and kidney disease (dialysis).

**Sponsored child dependent** – An individual who shares primary residence with UK-covered employee and sponsored adult dependent and has lived with UK employee at least twelve months prior to effective date of coverage. They must be under the age of 18, and the natural born or adopted child of sponsored adult dependent. Cannot be a relative of the covered UK employee (see the definition of relative for sponsored adult dependent below).

**Sponsored adult dependent** – An individual who shares primary residence with covered UK employee, and has lived with UK employee at least twelve months prior to effective date of coverage. They must be at least the age of majority, and cannot be a relative. Definition of relative for sopnsored adult dependent: parents, children, husbands, wives, brothers, sisters, brothers- and sisters-in-law, mothers- and fathers-in-law, uncles, aunts, cousins, nieces, great nieces, nephews, great nephews, grandmothers, grandfathers, great grandmothers, great grandfathers, sons- and daughers-in-law and half- or step-relatives of the same relationship.

*Incapacity is defined for purposes of this certification as inability to work, attend school, or perform other regular daily activities due to the serious health condition, treatment schedule or recovery period.

** Treatment includes examiniations to determine if a serious health condition exists and evaluations of the condition. Treatment does not include routine physical examinations, eye examinations, or dental examinations.

***A regimen of continuing treatment includes, for example, a course of prescription medication (e.g. an antibiotic) or therapy requiring special equipment to resolve or alleviate the health condition. A regimen of treatment does not include the taking of over-the-counter medications such as aspirin, antihistamines, or use of salves; or bed-rest, drinking fluids, exercise, and other similar activities that can be initiated without a visit to a health care provider.