UNIVERSITY OF KENTUCKY®

Request for Family and Medical Leave

Please return the completed certification form to your supervisor 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 FMLA request.

PART I is completed by the employee requesting leave.

PART II is completed by a health care provider. You may need to complete additional forms if you apply for Long Term Disability or workers' compensation benefits.

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 of unpaid leave in a 12 month period.
- If you currently receive employer paid health benefits coverage, you will be able to continue your basic insurance coverage during FMLA leave. For questions, please contact the Employee Benefits Office at (859) 257-9519 (press 1 for Benefits).
- As allowed under the law, and provided you comply with University policy, you will be returned to the same or an equivalent job with the same pay, benefits, and terms and conditions of employment on your return from FMLA leave, unless a reduction in force or reorganization impacts your position. If this happens, you may be separated from the University in accordance with the guidelines in effect for such situations.

For questions regarding the FMLA, please contact the HR Employee Relations Office at (859) 257-9555 ext. 128.

PART I – To Be Completed by Employee

Employee's Name (please print): **Employee's Person ID**: **Employee's Phone #: Home/Primary:**	**Department:** **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 (husband/wife) ☐ Child – Age
☐ Sponsored adult dependent ☐ Sponsored child dependent – Age
(If for family member, fill out PART IA)

☐ **Newborn or newly placed adoptive/foster child**

Regular Work hours per week	**Days per Week Scheduled to Work**	**Work Shift**
☐ 40 ☐ 37.5 ☐ 30 ☐ 20 ☐Other: _____	☐ M – F ☐Other: _____	☐ Days ☐ Evening ☐ Night ☐ Other: _____

I **am requesting leave:**	**I am requesting a reduced work schedule:**
From **to**:	From hours/week to hours/week

I am requesting an intermittent work schedule (describe requested schedule):

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's 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 the last page. (page 3)

Employee's Name	**Patient's Name**

Patient Health Condition Is patient's condition a "Serious Health Condition" as defined on pg. 4? ☐ Yes ☐ No	**If Yes, date condition commenced:**

If patient's condition meets one or more of the serious health condition definitions, please check the applicable category(ies):

☐ Hospital/Inpatient Care ☐ Absence plus treatment ☐ Pregnancy ☐ A 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 treatment/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 provider(s) 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:
hour(s) 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 episode

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 to 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 many 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 from 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).

* 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 examinations 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.