UNIVERSITY OF LOUISVILLE.

FAMILY MEMBER'S SERIOUS HEALTH CONDITION REQUEST FOR FAMILY MEDICAL LEAVE OF ABSENCE

Instructions for Section I

Human Resources is responsible for handling requests for Family Medical Leave under PER 4.17 and the Federal Family and Medical Leave Act of 1993 (FMLA). Please fully answer each item in Section I, then have your supervisor and department head sign the acknowledgement portion. Following the completion of Section I, submit the form to your healthcare provider to complete Section II. Forward completed forms and attachments to Human Resources, 1980 Arthur Street, Louisville, Kentucky 40208-2770, fax to (502) 852-2019, or e-mail to leaveadm@louisville.edu.

FMLA permits an employer to require that you submit a timely, complete and sufficient medical certification to support a request for family medical leave due to a family member's serious health condition. Failure to provide a complete and sufficient medical certification will result in a denial of your request. **Requests for information must be fulfilled within fifteen (15) calendar days.**

Section I: For Completion by Employee

Last Name: _____ First Name: _____

Mailing Address: _____

City: _____ State: _____ Zip Code: _____

E-mail: _____ Home/Mobile Phone: _____

UofL ID#: _____ Department: _____

Name of Department Timekeeper/UBM: _____

I am requesting a Family Medical Leave of Absence due to my family member's serious health condition:

◯ Yes ◯ No

Name of Family Member: _____ Relationship: _____

Describe the care you will provide to your family member and estimate the leave time needed to provide care:

_____

I have read and understand the ***Request Guidance*** document which includes information of my rights and responsibilities:

◯ Yes ◯ No

DEPARTMENT ACKNOWLEDGEMENT

I acknowledge that this employee has notified me that they are seeking approval of FML with Human Resources.

Supervisor Name and Signature: _____ Date: _____

Dept. Head Name and Signature: _____ Date: _____

EMPLOYEE AUTHORIZATION

I give UofL permission to explore necessary information from my department and/or health care provider in order to process this request, and acknowledge that such communication is job-related and consistent with business necessity. I understand that all information obtained during this process will be maintained and used in accordance with confidentiality requirements.

Print Name of Employee: _____

Signature of Employee: _____ Date: _____

Section II: For Completion by Healthcare Provider

The employee listed above has requested leave under the FMLA to care for your patient. Please fully answer each applicable item in this section. 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 your medical knowledge, experience, and examination of the patient. Please limit responses to the condition for which the employee is seeking leave. Do not provide information about genetic tests, genetic services, or the manifestation of disease or disorder in the employee's family members.

Healthcare Provider's Name: _____

Mailing Address: _____

City: _____ State: _____ Zip Code: _____

Phone Number: _____ Fax Number: _____

Type of practice/medical specialty: _____

Patient Medical Facts

Employee (Patient) Name: _____

Date condition commenced: _____ Probable duration of condition: _____

Was the patient admitted for an overnight stay in a hospital, hospice, or residential medical care facility? ◯ Yes ◯ No

If yes, dates of admission: _____

Date(s) you treated the patient for condition: _____

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? ◯ Yes ◯ No

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

_____

Is the medical condition pregnancy? ◯ Yes (Expected Delivery Date: _____) ◯ No

Amount of Care Needed

NOTE: When answering these questions, please keep in mind that your patient's need for care by the employee seeking leave may include assistance with basic medical, hygienic, nutritional, safety or transportation needs, or the provision of physical or psychological care.

1) Will the employee be incapacitated for a single continuous period of time due to his/her medical condition, including any time for treatment and recovery?

Yes No

If yes, estimate the beginning and ending dates of incapacity: _____ through _____

2) During this time, will the patient need care? Yes No

If yes, explain the care needed by the patient and why such care is medically necessary:

_____

3) Will the patient require follow-up treatments, including any time for recovery? Yes No

Estimate the treatment schedule, if any, including the dates of any scheduled appointments and the time required for each appointment, including any recovery period:

_____

Explain the care needed by the patient, and why such care is medically necessary:

_____

4) Will the employee be required to provide patient care on an intermittent or reduced schedule basis, including time for recovery?

Yes No

Estimate the hours the patient needs care on an intermittent basis:

_____ hour(s) per day; _____ days per week from _____ through _____

Explain the care needed by the patient, and why such care is medically necessary:

_____

5) Will the condition cause episodic flare-ups periodically preventing the patient from participating in normal daily activities?

Yes No

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

If yes, please 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:

Frequency: _____ time(s) per _____ week(s) _____month(s)

Duration: _____ hour(s) or _____ day(s) per episode

Explain the care needed by the patient during flare-ups, and why such care is medically necessary:

_____

Any additional information:

Signature of Healthcare Provider: _____ Date: _____

For University Use Only: Date Form Received: _____ Signature: _____