UNIVERSITY OF LOUISVILLE.

ILL/INJURED SERVICEMEMBER 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 acknowledgment 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, 215 Central Ave., suite 205 Louisville, Kentucky 40208-2770, e-mail to leaveadm@louisville.edu or fax to (502) 852-2019.

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 and/or the Current Servicemember for Whom the Employee is Requesting Leave:

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 care for a covered service member with a serious injury or illness, and the service member is my spouse, child, parent or next of kin:

◯ Yes ◯ No

Name of Family Member: _____ Relationship: _____

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: _____

Servicemember Information

Is the servicemember a current member of the Regular Armed Forces, the National Guard or Reserves?

◯ Yes ◯ No

If yes, please provide the servicemember's military branch, rank and unit currently assigned to:

_____

Is the servicemember assigned to a military medical treatment facility as an outpatient or to a unit established for the purpose of providing command and control of members of the Armed Forces receiving medical care as outpatients (such as a medical hold or warrior transition unit?

◯ Yes ◯ No

If yes, please provide the name of the medical treatment facility or unit:

_____

Is the servicemember on the Temporary Disability Retired List (TDRL)?

◯ Yes ◯ No

Care to be Provided to the Servicemember

Describe the care to be provided to the current servicemember and an estimate of the leave needed to provide the care:

EMPLOYEE AUTHORIZATION

I give UofL permission to explore necessary information from my department and/or a third party 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: _____

Instructions for Section II

The employee listed on Page 1 has requested leave under the FMLA to care for a family member who is a current member of the Regular Armed Forces, the National Guard, or the Reserves who is undergoing medical treatment, recuperation, or therapy, is otherwise in outpatient status, or is otherwise on the temporary disability retired list for a serious injury or illness. For purposes of FMLA leave, a serious injury or illness is one that was incurred in the line of duty on active duty in the Armed Forces or that existed before the beginning of the member's active duty and was aggravated by service in the line of duty on active duty in the Armed Forces that may render the servicemember medically unfit to perform the duties of his or her office, grade, rank, or rating.

A complete and sufficient certification to support a request for FMLA leave due to a current servicemember's serious injury or illness includes written documentation confirming that the servicemember's injury or illness was incurred in the line of duty on active duty or if not, that the current servicemember's injury or illness existed before the beginning of the servicemember's active duty and was aggravated by service in the line of duty on active duty in the Armed Forces, and that the current servicemember is undergoing treatment for such injury or illness by a health care provider listed above. 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 your 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 servicemember's condition for which the employee is seeking leave. Do not provide information about genetic tests, as defined in 29 CFR 1635.3(f), or genetic services, as defined in 29 CFR 1635.3(e).

Section II is to be completed by a United Stated Department of Defense ("DOD") Health Care Provider or Health Care Provider who is either: (1) a United States Department of Veterans Affairs ("VA") health care provider; (2) a DOD TRICARE network authorized private health care provider; (3) a DOD non-network TRICARE authorized private health care provider; or (4) a health care provider as defined in 29 CFR 825.125.

Section II: For Completion by Health Care Provider

Healthcare Provider's Name: _____

Mailing Address: _____

City: _____ State: _____ Zip Code: _____

Phone Number: _____ Fax Number: _____

Type of practice/medical specialty: _____

This practice is a (check one of the appropriate boxes):

- ☐ DOD health care provider
- ☐ VA health care provider
- ☐ DOD Tricare network authorized private health care provider
- ☐ DOD non-network TRICARE authorize private health care provider
- ☐ Health care provider as defined in 29 CFR 825.125

Medical Status

The current servicemember's medical condition is classified as (check one of the appropriate boxes):

- ◯ (VSI) Very Seriously Ill/Injured – Illness/injury is of such a severity that life is imminently endangered. Family members are requested at bedside immediately. (Please not this is an internal DOD casualty assistance designation used by DOD health care providers.)
- ◯ (SI) Seriously Ill/Injured – Illness/injury is of such severity that there is cause for immediate concern, but there is no imminent danger to life. Family members are requested at bedside. (Please not this is an internal DOD casualty assistance designation used by DOD healthcare providers.)
- ◯ OTHER Ill/Injured – a serious injury or illness that may render the servicemember medically unfit to perform the duties of the member's office, grade, rank, or rating.
- ◯ NONE OF THE ABOVE (note to employee: if this box is checked, you may still be eligible to take leave to care for a covered family member with a serious health condition.

Is the current servicemember being treated for a condition which was incurred or aggravated by service in the line of duty on active duty in the Armed Forces?

◯ Yes ◯ No

Approximate date condition commenced: _____

Probable duration of condition and/or need for care: _____

Is the servicemember undergoing medical treatment, recuperation, or therapy for this condition?

◯ Yes ◯ No

If yes, please describe:

_____

Servicemember's Need for Care by Family Member

Will the servicemember need care for a single continuous period of time, including any time for treatment and recovery?

◯ Yes ◯ No

If yes, estimate the beginning and ending dates for this period of time: _____

Will the servicemember require periodic follow-up treatment appointments?

◯ Yes ◯ No

If yes, estimate the treatment schedule: _____

Is there a medical necessity for the servicemember to have periodic care for these follow-up treatment appointments?

◯ Yes ◯ No

Is there a medical necessity for the servicemember to have periodic care for other than scheduled follow-up treatment appointments (e.g., episodic flare-ups of medical condition)?

◯ Yes ◯ No

If yes, please estimate the frequency and duration of the periodic care:

_____

Any additional information:

Signature of Healthcare Provider: _____ Date: _____

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