UNIVERSITY OF LOUISVILLE.

ILL/INJURED VETERAN
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 Veteran 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 veteran with a serious injury or illness, and the veteran is my spouse, child, parent or next of kin:

◯ Yes ◯ No

Name of Veteran: _____ 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: _____

Veteran Information

Date of the veteran's discharge: _____

Was the veteran dishonorably discharged or released from the Armed Forces (including the National Guard or Reserves)?

◯ Yes ◯ No

Please provide the veteran's military branch, rank and unit at the time of discharge:

_____

Is the veteran receiving medical treatment, recuperation, or therapy for an injury or illness?

◯ Yes ◯ No

Care to be Provided to the Veteran

Describe the care to be provided to the veteran 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 named in Section I has requested leave under the military caregiver leave provision of the FMLA to care for a family member who is a veteran. For purposes of FMLA military caregiver leave, a serious injury or illness means an injury or illness incurred by the servicemember in the line of duty on active duty in the Armed Forces (or that 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 manifested itself before or after the servicemember became a veteran and is:

(i) A continuation of a serious injury or illness that was incurred or aggravated when the covered veteran was a member of the Armed Forces and rendered the servicemember unable to perform the duties of the servicemember's office, grade, rank, or rating; or

(ii) A physical or mental condition for which the covered veteran has received a U.S. Department of Veterans Affairs Service Related Disability Rating (VASRD) of 50 percent or greater, and such VASRD rating is based, in whole or in part, on the condition precipitating the need for military caregiver leave; or

(iii) A physical or mental condition that substantially impairs the covered veteran's ability to secure or follow a substantially gainful occupation by reason of a disability or disabilities related to military service, or would do so absent treatment; or

(iv) An injury, including a psychological injury, on the basis of which the covered veteran has been enrolled in the Department of Veterans' Affairs Program of Comprehensive Assistance for Family Caregivers.

A complete and sufficient certification to support a request for FMLA leave due to a covered veteran's serious injury or illness includes written documentation confirming that the veteran's injury or illness was incurred in the line of duty on active duty or existed before the beginning of the veteran's active duty and was aggravated by service in the line of duty on active duty in the Armed Forces, and that the veteran is undergoing treatment for such injury or illness by a health care provider listed below. 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 veteran'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: (1) a United States Department of Defense ("DOD") Health Care Provider; (2) a United States Department of Veterans Affairs ("VA") health care provider; (3) a DOD TRICARE network authorized private health care provider; (4) a DOD non-network TRICARE authorized private health care provider; or (5) 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 veteran's medical condition is (check one of the appropriate boxes):

- ◯ A continuation of a serious injury or illness that was incurred or aggravated when the covered veteran was a member of the Armed Forces and rendered the servicemember unable to perform the duties of the servicemember's office, grade, rank, or rating.
- ◯ A physical or mental condition for which the covered veteran has received a U.S. Department of Veterans Affairs Service Related Disability Rating (VASRD) of 50% or higher, and such VASRD rating is based, in whole or in part, on the condition precipitating the need for military caregiver leave.
- ◯ A physical or mental condition that substantially impairs the covered veteran's ability to secure or follow a substantially gainful occupation by reason of a disability or disabilities related to military service, or would do so absent treatment.
- ◯ An injury, including a psychological injury, on the basis of which the covered veteran is enrolled in the Department of Veterans' Affairs Program of Comprehensive Assistance for Family Caregivers.
- ◯ None of the Above

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

◯ Yes ◯ No

If yes, please describe:

Veteran's Need for Care by Family Member

Note: "need for care" encompasses both physical and psychological care. It includes situations where, for example, due to his or her serious injury or illness, the veteran is unable to care for his or her own basic medical, hygienic, or nutritional needs or safety, or is unable to transport him or herself to the doctor. It also includes providing psychological comfort and reassurance which would be beneficial to the veteran who is receiving inpatient or home care.

Will the veteran 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 veteran require periodic follow-up treatment appointments?

◯ Yes ◯ No

If yes, estimate the treatment schedule: _____

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

◯ Yes ◯ No

Is there a medical necessity for the veteran 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: _____