UNIVERSITY OF LOUISVILLE.

FACULTY
SERIOUS HEALTH CONDITION REQUEST FOR FAMILY MEDICAL LEAVE OF ABSENCE

Instructions for Section I

The Provost's Office of Faculty Affairs is responsible for processing faculty 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, and have your department chair sign the acknowledgement portion. Send the completed Section I to your unit Faculty Affairs Office for processing. FMLA permits an employer to require that you submit a timely, complete and sufficient medical certification (Section II) to support a request for family medical leave due to your own serious health condition. Failure to provide a complete and sufficient medical certification will result in a denial of your request. If additional information is requested, it must be received 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/Lead Fiscal Officer: _____

I am applying for FML for my own serious health condition for the following leave type:

Intermittent Leave:	Continuous Leave:	Reduced Work Schedule:
From_____to _____	From_____to _____	From_____to _____

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

Yes No

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.

Signature of Employee: _____ Date: _____

DEPARTMENT ACKNOWLEDGEMENT

I acknowledge that this employee has notified me that they are seeking approval of Family Medical Leave

Dept. Chair Signature:_____Date: _____

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Instructions for Section II

Your patient has requested leave under the FMLA. Please fully answer each applicable item in this section. The employee should provide you with a copy of their job functions. 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. Forward completed form (pages 2 and 3) to Kitty de Voogd, email katherine.devoogd@louisville.edu, fax 502-852-0657, or mail to Kitty de Voogd, University of Louisville, Grawemeyer Hall, Suite 201, Louisville, KY 40292.

Section II: For Completion by Healthcare Provider

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 _____

Is the employee unable to perform any of his/her job functions due to the condition? Yes No

If yes, state the job functions the employee is unable to perform: _____

_____

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Amount of Leave Needed

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) Will the employee need to attend follow-up treatment appointments or work part-time or on a reduced schedule because of the employee's medical condition?

Yes No

If yes, are the treatments/reduced number of hours of work medically necessary? 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: _____

_____

Estimate the part-time or reduced work schedule the employee needs, if any: ____ hour(s) per day; _____ days per week from _____ through _____

3) Will the condition cause episodic flare-ups periodically preventing the employee from performing his/her job functions?

Yes No

Is it medically necessary for employee to be absent from work during 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

Any additional information:

Signature of Healthcare Provider:_____Date: _____

For University Use Only: Date Form Received: Signature: