

**FACULTY FAMILY MEMBER'S 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, then have your department chair sign the acknowledgement portion. Following the completion of Section I, submit the form to your healthcare provider to complete Section II. Forward completed form and attachments to Kitty de Voogd, email [katherine.devoogd@louisville.edu](mailto:katherine.devoogd@louisville.edu) or mail to Kitty de Voogd, Grawemeyer Hall Suite 201, Louisville, KY 40292.

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/Lead Fiscal Officer: \_\_\_\_\_

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

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 Family Medical Leave.

Department Chair Signature: \_\_\_\_\_ Date: \_\_\_\_\_

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## **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: \_\_\_\_\_

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**SECTION II BEGINS ON NEXT PAGE**

**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. Send completed forms and attachments to Paula Hensel, email [katherine.devoogd@louisville.edu](mailto:katherine.devoogd@louisville.edu) or fax 502-852-0657.

Healthcare Provider's Name: \_\_\_\_\_

Mailing Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Phone Number: \_\_\_\_\_ Fax Number: \_\_\_\_\_

Type of practice/medical specialty: \_\_\_\_\_

**Patient Medical Facts**

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 patient 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: \_\_\_\_\_

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For University Use Only: Date Form Received:

Signature:

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