

## FMLA REQUEST FOR LEAVE (Family and Medical Leave Act of 1993)

Please type or print

<p>Name of employee: _____ (First Name, Middle Initial, Last Name)</p> <p>Address of employee: _____</p> <p>Campus: _____</p> <p>Position: _____</p> <p>S.S.# _____</p>
<p>Reason for requested leave:</p> <p>a. <input type="checkbox"/> Birth of a son or daughter of the employee or in order to care for such son or daughter.</p> <p>b. <input type="checkbox"/> Placement of a son or daughter with the employee for adoption or foster care.</p> <p>c. <input type="checkbox"/> Employee's own serious health condition that makes him/her unable to perform job functions.</p> <p>d. <input type="checkbox"/> In order to care for spouse, child or parent with a serious health condition.</p> <p style="margin-left: 20px;">If a leave is for any reason "d", please check one:</p> <p style="margin-left: 40px;"><input type="checkbox"/> Spouse      <input type="checkbox"/> Child      <input type="checkbox"/> Parent</p> <p style="margin-left: 20px;">Also if reason (d), state name and address of relative:</p> <p>_____</p> <p>_____</p> <p>_____</p>
<p>Date which you wish to commence leave: _____</p> <p>Date of anticipated return to work : _____</p>
<p>Are you requesting leave on an intermittent or reduced leave schedule? (Only applicable for reasons "c" and "d" above.)</p> <p style="margin-left: 40px;"><input type="checkbox"/> Yes      <input type="checkbox"/> No</p> <p>If "yes", please indicate when you anticipate you will be available for work.</p>
<p>According to policy, when an employee is absent from work more than five working days for any of the conditions listed above, FMLA will be designated if the employee qualifies. To determine eligibility, please complete this form and return it to the Personnel Office. You will also need to contact the Personnel Office (extension 8054) in order to obtain the paperwork required by the FMLA.</p> <p>_____</p> <p>Employee Signature <span style="float: right;">_____</span> Date</p>

Certification of Health Care Provider for  
Employee's Serious Health Condition  
(Family and Medical Leave Act)

U.S. Department of Labor  
Wage and Hour Division



OMB Control Number 1235-0003  
Expires: 2/28/2015

**SECTION I: For Completion by the EMPLOYER**

**INSTRUCTIONS to the EMPLOYER:** The Family and Medical Leave Act (FMLA) provides that an employer may require an employee seeking FMLA protections because of a need for leave due to a serious health condition to submit a medical certification issued by the employee's health care provider. Please complete Section I before giving this form to your employee. Your response is voluntary. While you are not required to use this form, you may not ask the employee to provide more information than allowed under the FMLA regulations, 29 C.F.R. §§ 825.306-825.308. Employers must generally maintain records and documents relating to medical certifications, recertifications, or medical histories of employees created for FMLA purposes as confidential medical records in separate files/records from the usual personnel files and in accordance with 29 C.F.R. § 1630.14(c)(1), if the Americans with Disabilities Act applies.

Employer name and contact: \_\_\_\_\_

Employee's job title: \_\_\_\_\_ Regular work schedule: \_\_\_\_\_

Employee's essential job functions: \_\_\_\_\_

Check if job description is attached: \_\_\_\_\_

**SECTION II: For Completion by the EMPLOYEE**

**INSTRUCTIONS to the EMPLOYEE:** Please complete Section II before giving this form to your medical provider. The FMLA permits an employer to require that you submit a timely, complete, and sufficient medical certification to support a request for FMLA leave due to your own serious health condition. If requested by your employer, your response is required to obtain or retain the benefit of FMLA protections. 29 U.S.C. §§ 2613, 2614(c)(3). Failure to provide a complete and sufficient medical certification may result in a denial of your FMLA request. 20 C.F.R. § 825.313. Your employer must give you at least 15 calendar days to return this form. 29 C.F.R. § 825.305(b).

Your name: \_\_\_\_\_  
First Middle Last

**SECTION III: For Completion by the HEALTH CARE PROVIDER**

**INSTRUCTIONS to the HEALTH CARE PROVIDER:** Your patient has requested leave under the FMLA. 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 condition for which the employee is seeking leave. Please be sure to sign the form on the last page.

Provider's name and business address: \_\_\_\_\_

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

Telephone: ( ) \_\_\_\_\_ Fax: ( ) \_\_\_\_\_

**PART A: MEDICAL FACTS**

1. Approximate date condition commenced: \_\_\_\_\_

Probable duration of condition: \_\_\_\_\_

**Mark below as applicable:**

Was the patient admitted for an overnight stay in a hospital, hospice, or residential medical care facility?

\_\_\_ No \_\_\_ Yes. If so, 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? \_\_\_ No \_\_\_ Yes.

Was medication, other than over-the-counter medication, prescribed? \_\_\_ No \_\_\_ Yes.

Was the patient referred to other health care provider(s) for evaluation or treatment (e.g., physical therapist)?

\_\_\_ No \_\_\_ Yes. If so, state the nature of such treatments and expected duration of treatment:

\_\_\_\_\_

2. Is the medical condition pregnancy? \_\_\_ No \_\_\_ Yes. If so, expected delivery date: \_\_\_\_\_

3. Use the information provided by the employer in Section I to answer this question. If the employer fails to provide a list of the employee's essential functions or a job description, answer these questions based upon the employee's own description of his/her job functions.

Is the employee unable to perform any of his/her job functions due to the condition: \_\_\_ No \_\_\_ Yes.

If so, identify the job functions the employee is unable to perform:

\_\_\_\_\_

4. Describe other relevant medical facts, if any, related to the condition for which the employee seeks leave (such medical facts may include symptoms, diagnosis, or any regimen of continuing treatment such as the use of specialized equipment):

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**PART B: AMOUNT OF LEAVE NEEDED**

5. 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? \_\_\_ No \_\_\_ Yes.

If so, estimate the beginning and ending dates for the period of incapacity: \_\_\_\_\_

6. 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? \_\_\_ No \_\_\_ Yes.

If so, are the treatments or the reduced number of hours of work medically necessary?  
\_\_\_ No \_\_\_ Yes.

Estimate 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 \_\_\_\_\_

7. Will the condition cause episodic flare-ups periodically preventing the employee from performing his/her job functions? \_\_\_ No \_\_\_ Yes.

Is it medically necessary for the employee to be absent from work during the flare-ups?  
\_\_\_ No \_\_\_ Yes. If so, 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 (e.g., 1 episode every 3 months lasting 1-2 days):

Frequency : \_\_\_\_\_ times per \_\_\_\_\_ week(s) \_\_\_\_\_ month(s)

Duration: \_\_\_\_\_ hours or \_\_\_\_\_ day(s) per episode

**ADDITIONAL INFORMATION: IDENTIFY QUESTION NUMBER WITH YOUR ADDITIONAL ANSWER.**

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\_\_\_\_\_  
**Signature of Health Care Provider**

\_\_\_\_\_  
**Date**

**PAPERWORK REDUCTION ACT NOTICE AND PUBLIC BURDEN STATEMENT**

If submitted, it is mandatory for employers to retain a copy of this disclosure in their records for three years. 29 U.S.C. § 2616; 29 C.F.R. § 825.500. Persons are not required to respond to this collection of information unless it displays a currently valid OMB control number. The Department of Labor estimates that it will take an average of 20 minutes for respondents to complete this collection of information, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. If you have any comments regarding this burden estimate or any other aspect of this collection information, including suggestions for reducing this burden, send them to the Administrator, Wage and Hour Division, U.S. Department of Labor, Room S-3502, 200 Constitution Ave., NW, Washington, DC 20210. **DO NOT SEND COMPLETED FORM TO THE DEPARTMENT OF LABOR; RETURN TO THE PATIENT.**