

Request for Family and Medical Leave

Serious injury or illness of covered servicemember for Military Family Leave

Please return the completed certification form to your supervisor within 15 calendar days of receipt of this application or the date condition commenced. **Failure to provide a complete and sufficient medical certification may result in denial of your FMLA request.** PART I is completed by the employee requesting leave. PART II is completed by a United States Department of Defense (DOD) health care provider or a health care provider who is either: (1) a United States Department of Veterans Affairs health care provider; (2) DOD Tricare network authorized private health care provider; or (3) a DOD non-network Tricare authorized private health care provider

Employee Information:

If you meet the eligibility requirements under the federal Family and Medical Leave Act (FMLA):

- You have a right to receive up to 26 weeks of unpaid leave in a 12 month period.
- If you currently receive employer paid health benefits coverage, you will be able to continue your basic insurance coverage during FMLA leave. For questions, please contact the HR Employee Benefits Office at (859) 257-9519 (press 1 for Benefits).
- As allowed under the law, and provided you comply with University policy, you will be returned to the same or an equivalent job with the same pay, benefits, and terms and conditions of employment on your return from FMLA leave, unless a reduction in force or reorganization impacts your position. If this happens, you may be separated from the University in accordance with the guidelines in effect for such situations.

For questions regarding the FMLA, please contact HR Employee Relations at (859) 257-9555, ext. 128.

PART I – To Be Completed by Employee

Employee's Name (please print):		Department:	
Employee's Person ID:		Supervisor:	
Employee's Phone #: Home/Primary _____			
Family and Medical Leave is needed to care for (check one): Relationship of Employee to Covered Servicemember			
Relationship: <input type="checkbox"/> Parent (not parent-in-law) <input type="checkbox"/> Spouse (husband/wife) <input type="checkbox"/> Child <input type="checkbox"/> Next of Kin			
Regular Work hours per week <input type="checkbox"/> 40 <input type="checkbox"/> 37.5 <input type="checkbox"/> 30 <input type="checkbox"/> 20 <input type="checkbox"/> Other _____	Days per Week Scheduled to Work <input type="checkbox"/> M – F <input type="checkbox"/> Other _____	Work Shift <input type="checkbox"/> Days <input type="checkbox"/> Evening <input type="checkbox"/> Night <input type="checkbox"/> Other _____	
I am requesting leave: From (Date) _____ to (Date) _____		I am requesting a reduced work schedule: From _____ hours/week to _____ hours/week	
I am requesting an intermittent work schedule (describe requested schedule): 			
If you are requesting a reduced or intermittent work schedule because of your own serious health condition, please provide your health care provider with a description of your job tasks. If you need assistance, contact your supervisor.			
PART IA – Covered Servicemember Information			
Is the covered Servicemember a Current Member of the Regular Armed Forces, the National Guard or Reserves? <input type="checkbox"/> Yes <input type="checkbox"/> No			
If yes, please provide the covered servicemember's military branch, rank and unit currently assigned: 			
Is the covered 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)? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please provide the name of the medical treatment facility or unit: 			
Is the covered Servicemember on the Temporary Disability Retired List (TDRL) <input type="checkbox"/> No <input type="checkbox"/> Yes			
Describe the care to be provided to the covered servicemember and an estimate of the leave needed to provide the care: 			
Employee's Signature		Date	

PART II – To be Completed by a United States Department of Defense (DOD) health care provider or a health care provider who is either: (1) a United States Department of Veterans Affairs health care provider; (2) DOD Tricare network authorized private health care provider; or (3) a DOD non-network Tricare authorized private health care provider.

If you are unable to make certain of the military-related determinations contained below, you are permitted to rely upon determinations from an authorized DOD representative (such as a DOD recovery care coordinator). Please be sure to sign the form on the last page.

Type of Practice/Medical Specialty: _____

Please state whether you are either (1) a DOD health care provider; (2) a VA health care provider; (3) a DOD Tricare network authorized private health care provider; or (4) a DOD non-network Tricare authorized private health care provider:

Medical Status

- (1) Covered 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 note this is an internal DOD casualty assistance designation used by DOD healthcare 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 note 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.
- (2) Was the condition for which the Covered Servicemember is being treated incurred in line of duty on active duty in the armed forces? Yes No
- (3) Approximate date condition commenced: _____
- (4) Probable duration of condition and/or need for care: _____
- (5) Is the covered servicemember undergoing medical treatment, recuperation, or therapy? Yes No If yes, please describe medical treatment, recuperation or therapy:

Covered Servicemember's need for care by family member

- (1) Will the covered 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: _____
- (2) Will the covered servicemember require periodic follow-up treatment appointments? Yes No
 If yes, estimate the treatment schedule: _____
- (3) Is there medical necessity for the covered servicemember to have periodic care for these follow-up treatment appointments?
 Yes No
- (4) Is there a medical necessity for the covered 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, estimate the frequency and duration of the periodic care:

Health Care Provider Information (please complete or attach business card with information)

Name (please print) _____ Specialty _____

Business Address _____

Phone _____

Health Care Provider Signature

Date