University of Kentucky

Request for Family and Medical Leave

Serious injury or illness of current 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 the applicant meets the eligibility requirements under the federal Family and Medical Leave Act (FMLA):

- The applicant a right to receive up to 26 weeks of unpaid leave in a 12-month period.
- If the applicant is currently receiving employer-paid health benefits coverage, he or she will be able to continue basic insurance coverage during FMLA leave. For questions, please contact HR Employee Benefits at (859) 257-9519, option 3.
- For information on FMLA and university policy, please refer to HR Policy 88.0 Family and Medical Leave Act. Policies are available online at www.hr.uky.edu.
- Send completed application directly to FML administration:

Fax: 859-257-2010 or 859-257-1679 **Email:** LeaveAdminFMLA@uky.edu
With questions, call FML administration at 859-323-0256 or 859-323-4259.
FOR FACULTY Below is the link to policy and how to upload (portal) FML. For questions about Faculty FML, email facultyadv@uky.edu. LINK: https://ofa.uky.edu/policies-procedures/faculty-leaves-absence Fax: 859-257-2987

PART I – To Be Completed by Employee

Employee's Name (please print):	Department:
Employee's Person ID: Employee's Phone #: Home/Primary _____	Supervisor:

Family and Medical Leave is needed to care for (check one):
Relationship of Employee to Covered Servicemember

Relationship: ☐ Parent (not parent-in-law) ☐ Spouse (husband/wife) ☐ Child ☐ Next of Kin

Regular Work hours per week	Days per Week Scheduled to Work	Work Shift
☐ 40 ☐ 37.5 ☐ 30 ☐ 20 ☐ Other ___	☐ M – F ☐ Other _____	☐ Days ☐ Evening ☐ Night ☐ Other ____

I am requesting leave:	I am requesting a reduced work schedule:
From (Date) _____ to (Date) _____	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 Regualr Armed Forces, the National Guard or Reserves? ☐ Yes ☐ 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)? ☐ Yes ☐ 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) ☐ No ☐ Yes

Describe the care to be provided to the current 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 Veterns 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) Current Servicemember's medical condition is classified as (Check on e 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.
☐ **None of the above** (Note to Employee: if this box is checked, you may still be eligible to take leave to care for a covered family member with a "serious health condition." If such leave is requested, you may be required to complete DOL FORM WH-380-F or an employer-provided form seeking the same information.)

(2) Is the current servicemember 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

(3) Approximate date condition commenced: _____

(4) Probable duration of condition and/or need for care: _____

(5) Is the current servicemember undergoing medical treatment, recuperation, or therapy?
☐ Yes ☐ No If yes, please describe medical treatment, recuperation or therapy:

Current servicemember's need for care by family member

(1) Will the 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 servicemember require periodic follow-up treatment appointments? ☐ Yes ☐ No
If yes, estimate the treatment schedule: _____

(3) Is there medical necessity for the 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