

Request for Family and Medical Leave

Serious injury or illness of a veteran 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 HREmployee 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**

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: Parent (no parent-in-law) Spouse(husband/wife) Child Next of kin

Regular hours per week:

40 37.5 30 20 Other

Days per week Scheduled to Work:

M-F Other

Work shift:

Days Evenings Nights
Other

I am requesting leave:

From (date) To (date)

I am requesting a reduced work scheduled:

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 1A - Covered Veteran Information

Is the covered Veteran a Current Member of the Regular 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 veteran 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)? Yes No

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 B - Veteran Information

- (1) Date of the veterans' discharge: _____
- (2) Was the veteran dishonorably discharged or released from the Armed Forces (including the National Guard or Reserves)?
Yes No
- (3) Please provide the veteran's military branch, rank, and unit at the time of discharge: _____
- (4) Is the veteran receiving medical treatment, recuperation, or therapy for an injury or illness? Yes No

PART C - Care to be Provided to the Veteran

- (3) Describe the care to be provided to the veteran and an estimate of the leave needed to provide the care: _____

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.

PART A - Healthcare Provider Information

Healthcare provider's name and business address: _____

Telephone: _____ Fax: _____ Email: _____

Type of Practice/Medical Specialty: _____

Please indicate if you are:

- a DOD health care provider.
- a VA health care provider.
- a DOD Tricare network authorized private health care provider.
- a DOD non-network Tricare authorized private health care provider.
- other health care provider.

PART B - Medical Status

- (1) Current Veteran's medical condition is:
A continuation of a serious injury or illness that was incurred or aggravated when the covered veteran was a member of the Armed Forces and rendered the veteran unable to perform the duties of the veteran's office, grade, rank, or rating.
(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 the medical treatment, recuperation or therapy: _____

PART B - Medical Status

"Need for care" encompasses both physical and psychological care. It includes situations where, for example, due to his or her serious injury or illness, the veteran is unable to care for his or her own basic medical, hygienic, or nutritional needs or safety, or is unable to transport him or herself to the doctor. It also includes providing psychological comfort and reassurance which would be beneficial to the veteran who is receiving inpatient or home care.

(1) Will the veteran 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 veteran require periodic follow-up treatment appointments? Yes No

If yes, estimate the treatment schedule: _____

(3) Is there medical necessity for the veteran to have periodic care for these follow-up treatment appointments? Yes No

(4) Is there a medical necessity for the covered veteran 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 Signature

Date