Human Resources

Request for Family and Medical Leave

Please return the completed certification form to Family Medical Leave (FML) administration 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 an FML request.

- Part I is completed by the applilcant requesting leave.
- Part II is completed by a health care provider only.

Employee information
If the applicant meets the eligibility requirements under the federal Family and Medical Leave Act (FMLA):

- The applicant has a right to receive up to 12 weeks unpaid leave in a 12-month period.
- If the applicant is currently receiving employer-paid health benefits, he or she will be able to continue basic insurance coverage during FMLA leave. For more information, please contact HR 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.uky.edu/hr.**
- Send completed application directly to FML administration:

Fax to ***859-257-2010*** or ***859-257-1679*** Email: ***LeaveAdminFMLA@uky.edu***
With questions, call FML administration at ***859-323-0256*** or ***859-323-4259***

PART I: To be completed by employee (please print)

Employee name _____ Department _____

Employee person ID _____

Employee home or primary phone _____ Supervisor _____

Family and Medical Leave is needed to care for (check one):

☐ Personal health condition
☐ Family member's health condition (indicate relationship)
☐ Parent (not parent-in-law) ☐ Spouse ☐ Child (age:_____)
☐ Sponsored adult dependent ☐ Sponsored child dependent (age:_____)

NOTE: If for family member, please complete part IA

☐ Newborn or newly placed adoptive/foster child

Regular work hours per week
☐ 40 ☐ 37.5 ☐ 30 ☐ 20
☐ Other: _____

Days per week scheduled to work
☐ Monday-Friday
☐ Other: _____

Work shift
☐ Days ☐ Evening ☐ Night
☐ Other: _____

I am requesting leave
From: _____ To: _____

I am requesting a reduced work schedule
From _____ hours per week to _____ hours per week

I am requesting an intermittent work schedule (please describe in detail):

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: Leave to care for a family member

Briefly describe the care you will provide to your family member: ☐ Assisting with basic medical, hygenic, nutritional or safety needs
☐ Transportation ☐ Physical care ☐ Psychological comfort ☐ Other: _____

Employee signature **Date**

PART II: To be completed by 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 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 page 3.

Employee's name _____ Patient's name _____

Serious Health Condition:

Is the patient's health condition a "Serious Health Condition" as defined on page 4? ☐ Yes ☐ No

If yes, date the condition commenced: _____

Check the boxes for the questions below, as applicable. For all boxes checked, the amount of leave needed must be provided in the Employee Work Schedule section.

☐ *Hospital/inpatient care:* The patient is/was admitted for an overnight stay in a hospital, hospice, or residential medical care facility on the following dates: _____

☐ *Incapacity plus treatment:* Due to the condition, the patient is/was incapacitated for *more than* three consecutive, full calendar days from _____ (mm/dd/yyyy) to _____ (mm/dd/yyyy)

(Note: For FMLA purposes, "incapacity" means the inability to work, attend school or perform regular daily activities due to the condition, treatment of the condition, or recovery from the condition.)

☐ *Pregnancy:* The condition is pregnancy and prenatal care. Expected delivery date: _____ (mm/dd/yyyy)

☐ *Chronic conditions: (e.g. asthma, migraine headaches)* Due to the condition, it is medically necessary for the patient to have treatment visits at least twice a year.

☐ *Permanent or long-term conditions: (e.g. Alzheimer's, terminal stages of cancer)* Due to the condition, incapacity is permanent or long term and requires continuing supervision of a health care provider (even if active treatment is not being provided).

☐ *Conditions requiring multiple treatments:* Due to the condition, it is medically necessary for the patient to receive multiple treatments.

Treatment Plan: Please provide the following information

Dates of treatment/follow-ups _____ Period required for recovery _____

Number of treatments/follow-ups _____ Interval between treatment(s) _____

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

Will the condition result in a "regimen of continuing treatment" under the supervision of a health care provider? *(e.g. therapy requiring special equipment to resolve or alleviate the health condition, oxygen)* ☐ Yes ☐ No

Was the patient referred to other health care providers for evaluation or treatment *(e.g. physical therapy)*? ☐ Yes ☐ No

If yes, state the nature of such treatments and expected duration of treatment:

Employee Work Schedule: If the employee must be absent from work, please provide the following information:

Select the type of leave you are recommending: ☐ ***Continuous*** ☐ ***Intermittent*** ☐ ***Reduced schedule***

Specific dates you are recommending employee be off of work: From _____ to _____

Is it necessary for the employee to work a reduced or intermittent work schedule because of the employee's or family member's health condition? ☐ Yes ☐ No

What is the duration of time that the recommended schedule should be in place? _____

Will this condition require planned medical treatments? *(e.g. psychotherapy, prenatal appointments)* ☐ Yes ☐ No

Will condition cause episodic flare-ups, preventing the employee from performing job functions? ☐ Yes ☐ No

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). Terms such as "unknown" or "indeterminate" may not be sufficient to determine FMLA coverage:

Frequency: _____ times per ☐ week(s) or ☐ month(s) **Duration: _____ hours or _____ day(s) per epidode**

Is it medically necessary for the employee to be absent from work during the flare-ups? ☐ Yes ☐ No

If yes, explain:

Essential Job Functions:

For patients who are UK employees: Is the patient able to perform all of their essential job functions? ☐ Yes ☐ No

If no, which functions cannot be performed?

Family Member Care:

If leave is required to care for an employee's family member, please respond to the following:

Does your patient require assistance for basic medical or personal needs, safety or transportation? ☐ Yes ☐ No

Would the employee's presence to provide psychological comfort be beneficial to the patient or assist in the patient's recovery? ☐ Yes ☐ No

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):

Health care provider information (please complete or attach business card with information)

Name (please print) _____ Specialty _____

Business address _____

Phone _____

Health care provider signature	***Date***

Serious health condition definitions in accordance with FMLA

Hospital/inpatient care — Inpatient care (i.e. an overnight stay) in a hospital, hospice, or residential medical care facility, including any period of incapacity* or subsequent treatment in connection to such inpatient care.

Absences for work plus treatment — A period of incapacity* of more than three consecutive calendar days (including any subsequent treatment or period of incapacity* relating to the same condition) that also involves:

1. Treatment** two or more times by a health care provider, by a nurse or physician's assistant under direct supervision of a health care provider, or by a provider of health care services (e.g. physical therapist) under orders of, or on referral by, a health care provider; or
2. Treatment ** by a health care provider on at least one occasion which results in a regimen of continuing treatment*** under the supervision of the health care provider.
3. The treatments must be within 30 days of when the condition starts. The first visit must be within 7 days.

Pregnancy — Any period of incapacity due to pregnancy or for prenatal care.

Chronic conditions requiring treatments — A chronic condition which:

1. Requires periodic visits of at least 2 annually for treatment by a health care provider, or by a nurse or physician's assistant under direct supervision of a health care provider;
2. Continues over an extended period of time (including recurring episodes of a single underlying condition); and
3. May cause episodic rather than a continuing period of incapacity* (e.g. asthma, diabetes, epilepsy, etc.).

Permanent/long-term conditions requiring supervision — A period of incapacity* which is permanent or long-term due to a condition for which treatment may not be effective. The employee or family member must be under the continuing supervision of, but need not be receiving active treatment by a health care provider. Examples include Alzheimer's, a severe stroke, or the terminal stages of a disease.

Multiple treatments (non-chronic conditions) — Any period of absence to receive multiple treatments (including any period of recovery there from) by a health care provider or by a provider of health care services under orders of, or on referral by a health care provider, either for restorative surgery after an accident or an injury, or for a condition that would likely result in a period of incapacity* of more than three consecutive calendar days in absence of medical intervention or treatment, such as cancer (chemotherapy, radiation, etc.), severe arthritis (physical therapy), and kidney disease (dialysis).

Sponsored child dependent — An individual who shares primary residence with UK-covered employee and sponsored adult dependent and has lived with UK employee at least twelve months prior to effective date of coverage. They must be under the age of 18, and the natural born or adopted child of sponsored adult dependent. Cannot be a relative of the covered UK employee (see the definition of relative for sponsored adult dependent below).

Sponsored adult dependent — An individual who shares primary residence with covered UK employee, and has lived with UK employee at least twelve months prior to effective date of coverage. They must be at least the age of majority, and cannot be a relative. Definition of relative for sopnsored adult dependent: parents, children, husbands, wives, brothers, sisters, brothers- and sisters-in-law, mothers- and fathers-in-law, uncles, aunts, cousins, nieces, great nieces, nephews, great nephews, grandmothers, grandfathers, great grandmothers, great grandfathers, sons- and daughers-in-law and half- or step-relatives of the same relationship.

*Incapacity is defined for purposes of this certification as inability to work, attend school, or perform other regular daily activities due to the serious health condition, treatment schedule or recovery period.

** Treatment includes examiniations to determine if a serious health condition exists and evaluations of the condition. Treatment does not include routine physical examinations, eye examinations, or dental examinations.

***A regimen of continuing treatment includes, for example, a course of prescription medication (e.g. an antibiotic) or therapy requiring special equipment to resolve or alleviate the health condition. A regimen of treatment does not include the taking of over-the-counter medications such as aspirin, antihistamines, or use of salves; or bed-rest, drinking fluids, exercise, and other similar activities that can be initiated without a visit to a health care provider.