UK UNIVERSITY OF KENTUCKY

Request for Family and Medical Leave

Serious injury or illness of a veteran for Military Caregiver 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 3 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. 7.

SECTION 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 Veteran

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

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 A – Covered Veteran Information

Is the covered Veteran a Current Member of the Regualr Armed Forces, the National Guard or Reserves? ☐ Yes ☐ No

If yes, please provide the covered veteran'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 Veteran on the Temporary Disability Retired List (TDRL) ☐ No ☐ Yes

Describe the care to be provided to the current veteran 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

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

_____

_____

_____

_____

SECTION II – For completion by: (1) a United States Department of Defense ("DOD") health care provider; (2) a United States Department of Veterans Affairs ("VA") health care provider; (3) a DOD TRICARE network authorized private health care provider; (4) a DOD non-network TRICARE authorized private health care provider; or (5) a health care provider as defined in 29 CFR 825.125.

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.
☐ A physical or mental condition for which the covered veteran has received a U.S. Department of Veterans Affairs Service Related Disability Rating (VASRD) of 50% or higher, and such VASRD rating is based, in whole or in part, on the condition precipitating the need for military caregiver leave.
☐ A physical or mental condition that substantially impairs the covered veteran's ability to secure or follow a substantially gainful occupation by reason of a disability or disabilities related to military service, or would do so absent treatment.
☐ An injury, including a psychological injury, on the basis of which the covered veteran is enrolled in the Department of Veterans' Affairs Program of Comprehensive Assistance for Family Caregivers.
☐ None of the above.

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

PART C – Veteran's Need for Care by Family Member

"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 Information (please complete or attach business card with information)

Name (please print) _____ Specialty _____

Business Address _____

Phone _____

Health Care Provider Signature	Date