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| **FAMILY MEDICAL LEAVE - Certification Form** |  |

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| **NOTE: Return this form in 15 calendar days. PART II of this form must be completed by a Health Care Provider.**  |  |

**PART I: EMPLOYEE/PATIENT INFORMATION**

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| Employee Name: |       |  | **REASON FOR LEAVE REQUEST** |
| Employee Email: |       |  | **[ ]**  Serious Health Condition of the Employee |
| Employee Phone: |       |  | **[ ]**  New Child: **[ ]**  Birth **[ ]**  Adoption **[ ]**  Foster Care Placement |
| Employee ID#: |       |  |
| Supervisor Name: |       |  | **[ ]**  Serious Health Condition of a: **[ ]** Parent **[ ]** Child **[ ]**  Spouse **[ ]** Covered Military Member |
| Supervisor Email: |       |  |

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| **A.** | **FOR A BIRTH, ADOPTION OR FOSTER CARE PLACEMENT** |
| **NOTE:** For birth-related leave, Part II of this form is not required unless one, or both of the following apply:* The period of medical disability is expected to exceed a typical birth (normally 6-8 weeks)
* You apply for Voluntary Shared Leave
 |
| **For PregnancyExpected Date of Birth:** | **For Adoption or Foster CareExpected Date to Begin Care of Child:** |
|       |       |
| **Authorization:** I affirm that the information provided regarding my medical leave request is true and accurate to the best of my knowledge. I authorize the release of any medical information or adoption/foster care documents necessary to process this request. |
| Employee's Signature: |  | Date: |       |

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| **B.** | **FOR A MEDICAL CONDITION OF THE EMPLOYEE** |
| List essential job duties as well as those that will be affected most directly by absences, treatment, or recovery due to a serious health condition: |
|       |
| **Authorization:** I affirm that the information provided regarding my medical leave request is true and accurate to the best of my knowledge. I authorize the release of any medical information necessary to process this request. |
| Employee's Signature: |  | Date: |       |

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| **C.** | **For a medical condition of an immediate family member** |
| Patient Name: |       |
| Relationship to Employee: |       |
| Type of Care to be Provided by Employee: |       |
| Estimate of Time for Providing Care: |       |
| **Authorization:** I affirm that the information provided regarding this medical condition is true and accurate to the best of my knowledge. I authorize the release of any medical information necessary to process this request. |
| Patient’s Signature: |  | Date: |       |

**PART II: CERTIFICATION OF QUALIFYING CONDITION (to be completed by the Health Care Provider)**

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| **Name of Health Care Provider:** |       |
| **Name of Health Care Practice:** |       |
| **Address:** |       |
| **Phone:** |       | **Date of Examination:** |       |
| **Name of Employee:** |       | **Name of Patient:** |       |
| A “serious health condition” is an illness, injury, impairment, or physical or mental condition such that inpatient care is required or such that absences from employment are necessary on a recurring basis or are necessary for more than a few days for treatment or recovery. The information sought on this form relates only to the condition(s) for which the employee is seeking medical leave. Examples of a serious health condition include: heart attacks, heart conditions requiring heart bypass or valve operations, most cancers, back conditions requiring extensive therapy or surgical procedures, strokes, severe respiratory conditions, spinal injuries, appendicitis, pneumonia, emphysema, severe arthritis, severe nervous disorders, injuries caused by serious accidents on or off the job, ongoing pregnancy, severe morning sickness, the need for prenatal care, childbirth and recovery from childbirth. |
| **Brief Description of Condition:**       | **Date this condition began:** |
| **For medical condition of the employee:** Is the employee able to perform the essential functions of his/her position (listed on page 1) during this period? | [ ]  YES [ ]  NO |
| **For medical condition of a family member:** Is the employee’s absence from work necessary for and/or beneficial to the care and recovery of this Patient? | [ ]  YES [ ]  NO |
| **Period of time Patient is expected to be under medical care for this condition:**(Note: Annual re-certification may be required for conditions lasting more than 1 yr.) | From:  |       | To: |       |
| **(A) Period of time Employee is expected to be absent from work for this condition (meaning employee cannot work at all)** *Complete (A) or (B), not both***:**  | From:  |       | To: |       |
| **Indicate the type of the Patient’s serious medical condition. Check all that apply:** | **(B) Specify below the duration and/or frequency that would require the Employee to be absent from work sporadically or intermittently due to this serious health condition:** |
| **[ ]**  | Condition requiring short-term incapacity/absence | Period of time of sporadic or intermittent absences from work: From:       To:      List the duration and/or frequency:     Other information:      |
| **[ ]**  | Condition requiring short-term treatment |
| **[ ]**  | Chronic condition requiring recurrent treatment |
| **[ ]**  | Chronic condition requiring recurrent absence |
| **[ ]**  | Incapacity due to complications of pregnancy |
| **[ ]**  | Other qualifying condition (*Specify*):      |
| **[ ]**  | In-patient care required |
| **[ ]**  | None of the above / Does not qualify |
| **CERTIFICATION:** I affirm that the information provided above is true and accurate to the best of my knowledge.  |
| **Signature of Health Care Provider:** |  |  | **Date**: |       |

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|  **PLEASE SEND THIS FORM TO:** | **EMPLOYER CONTACT:**  |
|  UNCG Human Resources PO Box 26170 Greensboro, NC 27402 (336) 334-5009 | UNCG Benefitsbenefits@uncg.eduFax: (336) 334-5585 or (336) 334-3065 |
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