CAPITAL UNIVERSITY
REQUEST FOR FAMILY AND MEDICAL LEAVE OF ABSENCE

Name: _____ Department: _____

Hire Date: _____ Supervisor: _____

TYPE OF LEAVE REQUESTED

I request a Family or Medical Leave of absence for the following reason:

- ○ My personal serious health condition
- ○ Birth of my child
- ◉ Adoption of a child by me
- ○ Placement by the state of a child with me for foster care
- ○ Serious health condition of my child
- ○ Serious health condition of my parent
- ○ Serious health condition of my spouse
- ○ Military family/caregiver leave

I am requesting leave beginning _____ and ending _____.

I am requesting ○ intermittent leave or ○ reduced work schedule leave

If the request is for multiple days off for recurring medical treatments of the employee or employee's child, parent or spouse, specify the dates requested:

I ○ do ○ do not have a spouse who is also employed with Capital University.

I CERTIFY THAT I HAVE READ AND AGREE TO ABIDE BY THE UNIVERSITYS FAMILY AND MEDICAL LEAVE POLICY AND TO SUPPLY THE INFORMATION LISTED ON THE ATTACHED LEAVE CERTIFICATION REQUIREMENT SHEET.

_____ _____

Signature Date

_____ _____

Supervisor's Signature Date

Copy to employee
Original in employee's medical file

CAPITAL UNIVERSITY
PHYSICIAN CERTIFICATION FOR FAMILY or MEDICAL LEAVE

Section I. **To be completed by the employee.**

Name: _____ Date: _____

Department: _____ Social Security Number: _____

Full Time: _____ Part Time: _____

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Section II. **To be completed by the physician. Please assist us by clarifying the facts about the information below.**

As a duly authorized medical provider, I certify that I am currently treating:

◯ the Employee ◯ Spouse of the Employee ◯ Parent of the Employee ◯ Child of the Employee

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The backside of this form describes what is meant by a "serious health condition" under the Family Medical Leave Act. Does the patient's condition qualify under any of the categories described? If so, please check the applicable category.

◯ Hospital Care ◯ Absence Plus Treatment ◯ Pregnancy ◯ Chronic Conditions Requiring Treatments
◯ Permanent/Long-Term Conditions Requiring Supervision ◯ Multiples Treatments (Non-Chronic Conditions)
◯ None of the above_____ _____

Describe the medical facts which support your certification, including a brief statement as to how the medical facts meet the criteria of one of these categories.

The condition began on _____.

In my opinion, the condition will last until (provide date if possible)_____.

As a result of the condition, it is my opinion, that:

☐ The employee is currently unable to perform his/her employment functions set forth on the attached job description.
☐ The employee is currently needed to care for the patient (please explain).
☐ Intermittent Leave is medically necessary for the employee, or to care for the patient (please explain).
☐ None of the above.

In my opinion, it will be necessary for the above listed employee:

◯ to be on leave from work beginning on _____ and lasting until _____.

Or

◯ to be on an intermittent or reduced schedule for the following dates: _____.

Physician's Comments:

_____ _____
Physician's Signature Date

_____ _____
Physician's Printed Name Telephone Number

_____
Street Address

_____
City, State, and Zip Code

A "**Serious Health Condition**" means an illness, injury impairment, or physical or mental condition that involves one of the following:

1. Hospital Care

Impatient care (*i.e.*, an overnight stay) in a hospital, hospice, or residential medical care facility, including any period of incapacity[2] or subsequent treatment in connection with or consequent to such inpatient care.

2. Absence Plus Treatment

(a) A period of incapacity[2] of **more than three consecutive calendar days** (including any subsequent treatment or period of incapacity[2] relating to the same condition), that also involves:

(1) **Treatment**[3] **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**[4] under supervision of the health care provider.

3. Pregnancy

Any period of incapacity due to **pregnancy**, or for **prenatal care**.

4. Chronic Conditions Requiring Treatments

A **chronic condition** which:

(1) Requires **periodic visits** 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[2] (*e.g.* asthma, diabetes, epilepsy, etc.)

5. Permanent/Long-Term Conditions Requiring Supervision

A period of **Incapacity**[2] 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.

6. Multiples Treatments (Non-Chronic Conditions)

Any period of absences to receive **multiple treatments** (including any period of recovery therefrom) 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 other injury, or for a condition that **would likely result in a period of Incapacity**[2] **of more than three consecutive calendar days in the absence of medical intervention or treatment**, such a s cancer (chemotherapy, radiation, etc.) severe arthritis (physical therapy), and kidney disease (dialysis).

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1 Here and elsewhere on this form, the information sought relates **only** to the condition for which the employee is taking FMLA leave.
2. "Incapacity," for purposes of FMLA, is defined to mean inability to work, attend school or perform other regular daily activities due to the serious health condition, treatment therefore, or recovery therefrom.
3. Treatment includes examinations 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.
4. 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 salves; or bed-rest, drinking fluids, exercise, and other similar activities that can be initiated without a visit to a health care provider.