

**NORTH CAROLINA A&T STATE UNIVERSITY
FACULTY SERIOUS ILLNESS & DISABILITY LEAVE
MEDICAL CERTIFICATION STATEMENT**

1. Employee's Name	2. Patient's Name (if other than employee)
3. Describe the serious medical condition (illness, injury, impairment or physical or mental impairment that requires either inpatient care or continuing treatment) with requires leave	
4. Date condition commenced	5. Probable duration of condition
6. Explain why this employee is unable to work at all or is unable to perform any one of the essential functions of his/her position.	
If this certification relates to the employee caring for a family member, complete item 7. Otherwise proceed below.	
7. Will the employee's presence be necessary for the care of the patient? <input type="checkbox"/> Yes <input type="checkbox"/> No	
If yes, explain why? _____	
8.	
Signature of Treating Physician	Date
Treating Physician's name printed	
Treating Physician's Address and Telephone Number	
MEDICAL RELEASE:	
I authorize the release of any medical information necessary to process the above request:	
Patient's Signature	Date

Return the completed form to:
Human Resources, Benefits
1020 Wendover Ave Rm. 002
Greensboro, NC 27411

NORTH CAROLINA A&T STATE UNIVERSITY
REQUEST FOR FACULTY SERIOUS ILLNESS & DISABILITY LEAVE

Name: _____	DOB: _____
Department: _____	Work Phones: _____
Home Mailing Address: _____	
Home Phone: _____	Cellular Phone: _____
Beginning Date of Leave: _____	Expected return date: _____

Reason for Leave:

- Birth of a child or to care for a newborn child after birth
- Placement of or to care for a child placed for adoption or foster care
- Serious health condition of spouse, child, or parent
 - o Family member's Name: _____
 - o Relationship: _____
- Employee illness

This section to be completed by Employee: I hereby certify the information I have provided is accurate: Signature: _____ Date: _____

This section to be completed by Departmental Chair: Recommendation is to: Approve: ____ Deny: ____ Comments: _____ _____ _____ Signature: _____ Date: _____

This section to be completed by Dean or Vice Chancellor: Approved: ____ Denied: ____ Comments: _____ _____ _____ Signature: _____ Date: _____
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