The University of North Carolina at Chapel Hill
Office of Human Resources

MEDICAL & PARENTAL LEAVE – CERTIFICATION FORM

NOTE: For use only with requests for Family & Medical Leave, Family Illness Leave, Voluntary Shared Leave, and/or Leave without Pay due to medical reasons. Use also for Faculty Serious Illness, Major Disability, and Parental Leave. Refer to the appropriate policies for more information on eligibility and restrictions. Not for use with routine sick leave.
PART II of this form must be completed by a Health Care Provider. A copy of this Medical Certification Form must not be kept in a Department personnel file.

PART I: EMPLOYEE/PATIENT INFORMATION & AUTHORIZATION

Employee Name:		PID #:	
Dept Name:		Dept #:	
CB #:		Work Phone:	
Home Address:		Home Phone:	

FOR A BIRTH, ADOPTION OR FOSTER CARE PLACEMENT

NOTE: For birth-related leave, Part II of this form is required only if the period of medical disability is expected to exceed a typical birth (normally 6-8 weeks).	**FOR PREGNANCY** **Expected Date of Birth:**	**FOR ADOPTION OR FOSTER CARE** **Expected 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:

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:

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:

MEDICAL & PARENTAL LEAVE – CERTIFICATION FORM

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

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:
Period of time Employee is expected to be absent from work for this condition: (Note: Leave blank if absences are sporadic or intermittent.)	From: To:

Indicate the type of the Patient's serious medical condition. Check all that apply:	**Specify the duration and/or frequency of care that would require the Employee to be absent from work due to this serious health condition:**
☐ Condition requiring short-term incapacity/absence	
☐ 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:

FOR FACULTY, SPA & EPA NON-FACULTY:
Return this Form, along with Medical Leave Request Form, Leave Records, and any supporting documentation to:
Benefits Services Department, 104 Airport Drive, CB# 1045, Chapel Hill, NC 27599-1045.