APPLICATION FOR LEAVE OF ABSENCE
EMPLOYEE APPLICATION

This packet must be completed in its entirety as far in advance as possible; at least 30 days for a foreseeable leave, or **as soon as practicable** for an unforeseeable leave. For more info on FMLA see Policy # 3364-25-30.

Name: ____ Department:______________________________

Immediate Supervisor: _________________________________ Your Work Phone: _________________________

FAMILY AND MEDICAL LEAVE OF ABSENCE

I need a [check all that apply]:

- ☐ Full-time leave **from:** ______________________ **through:** ______________________
- ☐ Intermittent leave **from:** ______________________ **through:** ______________________
- ☐ Reduced schedule leave

If request is for an intermittent or reduced schedule leave the reason is [check one]:

- ☐ Chronic serious health condition
- ☐ Planned medical treatments
- ☐ Permanent/long-term serious health condition
- ☐ other

For "other" please describe. For planned medical treatments or reduced leave schedule, indicate the schedule you prefer.

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NON-FMLA LEAVES

I wish to apply for the following type of leave for myself [check one]:

- ☐ Sick leave
- ☐ Paternity/Maternity leave
- ☐ Unpaid leave
- ☐ Military leave*

* *Attach a copy of your official orders, issued by the President of the United States, Congress, or the Governor AND an official copy of monthly military pay and allowances pursuant to section 5919.29 of the Ohio Revised Code.*

START OF LEAVE: I would like to begin the leave on: ____

END OF LEAVE: I anticipate the leave needs to continue through: ______________________________________

I understand that if any dates change, I need to give the Human Resources Department as much notice as possible. I also understand that if I qualify for FMLA, recertification may be required. I understand that I must follow any and all departmental and organizational call in procedures for each day I am scheduled to work until I receive official written documentation of my leave approval, if applicable.

I understand that I must continue to pay for the same portion of my health care coverage (if any) that I normally pay during active employment in order for my coverage to continue throughout the leave. I understand that I must return to work the first business day after my leave ends. If I do not, my employment may be discontinued. Depending on my reason for not returning, I may have to reimburse the University of Toledo for the cost of health care premiums during the leave. If the need, as stated above, changes significantly, it is my responsibility to notify my employer. I understand that I cannot work for any other employer while on a leave from the University of Toledo.

EMPLOYEE'S Signature: ____ Date: ____________________

Main Campus Only: I wish to keep ______ hours of vacation (max 40 hrs) and ______ hours of sick time (max 40 hrs)

Hand Deliver or Mail to HR – Do Not Fax or Deliver faxed copies

CERTIFICATION BY HEALTH CARE PROVIDER
FAMILY MEDICAL LEAVE ACT 1993
Employee Certification

THE UNIVERSITY OF TOLEDO 1872

Human Resources, Mail Stop 405
2801 W. Bancroft St.,
Toledo, Ohio 43606-3390
419-530-4747

Ensure that all applicable fields are completed to avoid delays or denial of request.

EMPLOYEE INFORMATION and RELEASE – MUST BE COMPLETED BY EMPLOYEE

Name: ______________________________ Home Phone: ______________

UT email address______________________________ Rocket Number: ______________
(You will receive an email notification when a determination is made.) *(Can be found on your pay stub)*

I give my permission for this information concerning the medical condition for which this leave is being requested to be provided to The University of Toledo from whom family or medical leave is being requested. I hereby authorize a health care provider representing the University to contact my physician to verify my requested family and medical leave.

Employee Signature: ______________________________ Date: ______________

FOLLOWING TO BE COMPLETED & SIGNED BY HEALTH CARE PROVIDER as defined by the FMLA.

The Genetic Information Nondiscrimination Act of 2008 (GINA) prohibits employers and other entities covered by GINA Title II from requesting or requiring genetic information of an individual or family member of the individual, except as specifically allowed by this law. To comply with this law, we are asking that you not provide any genetic information when responding to this request for medical information. "Genetic information" as defined by GINA includes an individual's family medical history, the results of an individual's or family member's genetic test, the fact that an individual or an individual's family member sought or received genetic services, and genetic information of a fetus carried by an individual or an individual's family member or an embryo lawfully held by an individual or family member receiving assistive reproductive services.

1. Does the patient's condition qualify as a serious health condition under FMLA? ☐ YES ☐ NO

   If **YES**, please check the applicable category [MUST CHECK ONE]:

   ☐ **(1)** Inpatient Hospital Care ☐ **(2)** Absence Plus Treatment ☐ **(3)** Pregnancy ☐ **(4)** Chronic Condition
   ☐ **(5)** Permanent/Long-term Condition Requiring Supervision ☐ **(6)** Multiple treatments (Non-Chronic Conditions)

2. Complete all that apply (must have specific start and estimated end dates). Cannot exceed 12 months:

   Full Time Leave from: ______________ through: ______________

   AND/OR

   Intermittent Leave OR Reduced Schedule from: ______________ through: ______________

   Expected Return To Work: Date: ______________

3. Provide the medical facts/diagnosis which support your certification (only one condition per certification):

   ____

   ____

   ____

EMPLOYEE NAME: ____

4. A. State the approximate date the condition commenced (mm/dd/yy) _______________________________

   B. State the probable duration of the condition (mm/dd/yy) ___________________________________

   C. If this will be an **intermittent** or **reduced schedule** as a result of the condition give an estimate of the likely duration and frequency of episodes of incapacity we might expect due to this condition:

   ____

5. A. Are additional **treatments** required for the condition? ☐ YES ☐ NO

   If **YES**, provide an estimate of the probable number of such treatments: ____

   If the patient will be absent from work or other daily activities because of **treatment** on an **intermittent** or **part-time** basis, also provide an estimate or the probable number of and interval between such treatments, actual or estimated dates of treatment if known, and period required for recovery if any:

   Estimate or number of treatments required: _______________________

   Interval of treatments required: __________________________________

   Actual or Estimated dates of treatment: ___________________________

   Period of time requested for recovery: ___________________________

   B. Will any of these treatments be provided by **another** provider of health services (e.g. physical therapist)? ☐ YES ☐ NO

   If **YES**, please state the nature of the treatments:

   ____

   C. **Is a regimen of continuing treatment** by the patient required under your supervision? ☐ YES ☐ NO

   If **YES**, provide a general description of such regimen (e.g. prescription drugs, physical therapy requiring special equipment, etc.):

   ____

6. A. If medical leave is required for the **employee's absence from work** because of the **employee's own condition** (including absences due to pregnancy or a chronic condition) on a fulltime or intermittent basis, is the employee **able to perform** their current job assignment when at work (the employee should supply you with information about the essential job functions) ? ☐ YES ☐ NO

   If **NO**, is the employee able to perform work of any kind? ☐ YES ☐ NO

   B. If able to perform some work, what **essential functions of the employee's job** are they unable to perform?

   ____

   ____

CERTIFICATION: In signing this certification you are verifying that the above information is true to the best of your knowledge. Please be sure to include all medical facts completely and accurately that apply to the patient's condition. You may be contacted by a University of Toledo authorized Health Care Provider, Leave Administrator or other as allowed under the D.O.L. FMLA Regulations 29 C.F.R. § 825.307(a), to clarify and/or authenticate the certification.

Signature of Health Care Provider ____ Date ________________________

(Stamps will not be accepted)

Printed Name of Health Care Provider____

Address: ____ Type of Practice __________________________

____ Telephone Number _________________________

GIVE THIS ORIGINAL COMPLETED FORM TO THE EMPLOYEE. **FAXES OR COPIES NOT ACCEPTED.**