



THE UNIVERSITY OF
TOLEDO
1872

**UNIVERSITY OF TOLEDO HEALTH SCIENCE CAMPUS
FACULTY REQUEST FOR FAMILY OR MEDICAL LEAVE**

Requests for family or medical leave must be made, if practicable, at least thirty (30) days prior to the date the requested leave is to begin.

Name: _____ Department: _____

Rocket #: _____ Academic Rank/Title: _____

I request family or medical leave for one or more of the following reason(s):

_____ *A serious health condition* that prohibits me from performing my responsibilities.

_____ *The birth of my child* and to care for him/her.

_____ *Placement of a child* with me for adoption or foster care.

_____ *To care for an immediate family member* who has a *serious health condition**

***Serious health condition:** an illness, injury, impairment, disability or physical or mental condition that involves inpatient care in a hospital, hospice, or residential medical care facility, continuing treatment by or under the supervision of a health care provider, or exposure to a contagious disease that could be communicated to UTMC students, staff or patients. Serious health condition does not include voluntary or cosmetic treatment that is done on an outpatient basis and that is not medically necessary, or routine preventative physical exams.

Date Leave Will Begin: _____ Expected Return Date: _____

If applicable, *expected date of birth* or placement of adopted or foster child: _____

If requesting an intermittent or reduced schedule leave, please describe the leave schedule:

When the leave is to care for an ill family member or due to personal illness, provide the *Certification by Health Care Provider form* included in this packet.

I have read and agree to the terms and conditions of the Family Medical Leave Act Policy #3364-25-30

Faculty Member Requesting _____ Date: _____

ADMINISTRATIVE APPROVALS:

Department Chair _____ Date: _____

College Dean _____ Date _____

RETURN COMPLETED FORM TO FACULTY AFFAIRS



CERTIFICATION BY HEALTH CARE PROVIDER FAMILY MEDICAL LEAVE ACT 1993

Submit within 15 days after application for family and medical leaves involving illness.

EMPLOYEE INFORMATION – TO BE COMPLETED BY EMPLOYEE

Name: _____ Home Phone: _____

Department: _____ Supervisor: _____

PATIENT INFORMATION

Name: _____ Relationship to Employee: _____

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/Health Science Campus from whom family or medical leave is being requested.

Signature: _____ Date: _____

HEALTHCARE PROVIDER INFORMATION – TO BE COMPLETED BY HEALTH CARE PROVIDER

Name: _____ Phone: _____

Address: _____

Type of Practice (field of specialization, if any): _____

INFORMATION CONCERNING PATIENT CONDITION, STATUS

Is this a serious health condition as defined in The Family and Medical Leave Act of 1993? (See reverse side.) Yes No
If so, in which category? Check all that apply. 1) Hospital Care; 2) Absence Plus Treatment; 3) Pregnancy 4) Chronic Condition;
 5) Permanent/Long-term Condition Requiring Supervision; 6) Multiple Treatments (Non-Chronic Conditions)
Please describe the medical facts to support your diagnosis.

Approximate date on which condition commenced: _____ Probable duration of condition: _____
(mm/dd/yy) (mm/dd/yy)

Probable duration of Patient's present incapacity: _____ If the condition is a chronic condition (Condition 4) or pregnancy, is the patient currently incapacitated? Yes No What are the likely duration and frequency of episodes of incapacity?

Treatments: Are additional treatments required? Yes No If so, how many? _____ 1) What are the estimated dates of treatment?

2) What treatments, if any, will be provided by another provider of health care services such as a physical therapist? Describe

3) If a regimen of continuing treatment of the patient is required under your supervision, describe. (prescription drugs, PT, etc)

Illness of Family Member

Based on the employee's attached signed statement of need to provide care, is the employee's presence necessary or would it be beneficial to the patient? (May include psychological comfort) Yes No Estimate period of time care is needed by employee or employee's presence would be beneficial. _____

Illness of Employee

Does this condition prevent the employee from performing their current job assignment? Yes No If no, is the employee able to perform work of any kind? Describe: _____

Will it be necessary for the employee to work only intermittently or less than a full schedule as a result of the condition and/or treatment, either his own or to care for a seriously ill family member? Yes No If yes, give probable duration: _____

Signature of Health Care Provider: _____ Date: _____

A "SERIOUS HEALTH CONDITION" MEANS AN ILLNESS, INJURY, IMPAIRMENT, OR PHYSICAL OR MENTAL CONDITION THAT INVOLVES ONE OF THE FOLLOWING:

1. Hospital Care

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

2. Absence Plus Treatment

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

- a. Treatment* 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
- b. Treatment* by a health care provider on at least one occasion which results in a regimen of continuing treatment* under the 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:

- a. 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;
- b. Continues over an extended period of time (including recurring episodes of a single condition); and
- c. May cause episodic rather than a continuing period of incapacity* (e.g., asthma, diabetes, epilepsy, etc.).

5. Permanent/Long-term Conditions Requiring Supervision

A period of incapacity* 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. Multiple Treatments (Non-Chronic Conditions)

Any period of absence 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* of more than three consecutive calendar days in the absence of medical intervention or treatment, such as cancer (chemotherapy, radiation, etc.), severe arthritis (physical therapy), and kidney disease (dialysis).

PLEASE RETURN COMPLETED FORM TO THE EMPLOYEE OR TO THE OFFICE OF FACULTY AFFAIRS, UNIVERSITY OF TOLEDO HEALTH SCIENCE CAMPUS, 3000 ARLINGTON AVENUE, MAIL STOP #1063, TOLEDO, OHIO 43614.

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1. "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 therefor, or recovery therefrom.
 2. "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.
 3. "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.