THE UNIVERSITY OF ARIZONA
Human Resources

EMPLOYEE REQUEST FOR FAMILY AND MEDICAL LEAVE

Leave covered under the Family and Medical Leave Act (FMLA) must be designated as FMLA-protected and the employer must inform the employee of the amount of leave that will be counted against the employee's FMLA leave entitlement. In order to determine whether leave is covered under the FMLA, the employer may request that the leave be supported by a certification. If the certification is incomplete or insufficient, the employer must state in writing what additional information is necessary to make the certification complete and sufficient.

DATE: _____ DEPT #/NAME: _____

TO: _____ EMPL ID: _____
(Supervisor Name/Designated Leave Coordinator)

FROM: _____ EMPLOYEE PREFERED CONTACT #: _____
(Employee Name)

I believe I meet the eligibility requirements[1] of the Family and Medical Leave Act (FMLA) and I am therefore requesting a FMLA leave for the following reason:

Basic Leave Entitlement

☐ The birth of my child and/or to bond with the newborn child within one year of birth

☐ The placement of a child with me for adoption or foster care and/or to bond with the newly placed child within one year of placement

☐ My own serious health condition*

☐ To care for my ☐ spouse, ☐ parent, ☐ child (age 18 or under, or a child over age 18 with a disability where the child is unable to perform the activities of daily living without assistance) who has a serious health condition*

☐ A Qualifying Exigency arising out of the fact that my ☐ spouse, ☐ child, or ☐ parent is a covered military member on covered active duty.

Military Family Leave Entitlement

☐ To care for a covered servicemember with a serious injury or illness. I am the servicemember's ☐ spouse, ☐ child ☐ parent, ☐ next of kin.

You may be required to furnish certification in accordance with University FMLA leave procedures by your supervisor/designated leave coordinator or other responsible administrator.

I am requesting leave beginning on: _____ and anticipated end date: _____
(Insert specific date) (MM/DD/YY) ***(Insert specific date)*** (MM/DD/YY)

I am requesting my leave as ☐ continuous ☐ intermittent ☐ reduced work schedule.

If you have indicated it will be necessary for your leave to be on an intermittent or reduced work schedule basis above, please list the proposed schedule of leave dates and durations, or if leave is not scheduled describe your anticipated need for leave (estimate the probable number of and interval between treatments or periods of incapacity). (Attach an additional list if more space is needed):

_____

_____

_____ _____

_____

[1] Eligibility requirements are: (1) at least 12 months cumulative service and worked at least 1,250 hours at the University during the 12 month period preceding the date the proposed FMLA leave is to begin; and (2) a qualifying reason for taking a FMLA leave; and (3) a remaining balance of FMLA leave satisfactory to cover the leave dates in the request. The following URL may help in determining eligibility: http://www.hr.arizona.edu/fmla/eligibility/calculator. Further information on FMLA leave is available at: www.hr.arizona.edu/fmla.

FMLA leave runs concurrently with the use of the eligible employee's accrued paid time benefits, as applicable, (i.e., sick time, vacation time, paid parental leave, and, for non-exempt employees, compensatory time), approved use of compassionate transfer of leave, and during the receipt of any disability/insurance plan payments (i.e., short-term disability, long-term disability, or worker's compensation). A period of FMLA leave will be unpaid if the employee is not eligible for accrued paid time or exhausts his or her balance of accrued paid time.

An eligible employee's use of approved FMLA leave will be recorded on the employee's official time records and counted toward the employee's basic leave entitlement or military family leave entitlement until the available leave entitlement is exhausted. Use of FMLA leave may be tentatively entered into the eligible employee's official time record while awaiting sufficient information or certification to confirm a FMLA-qualifying reason exists.

_____ _____

Employee Signature Date

FORM ROUTING

Employee: Return original completed form to Supervisor/Designated Leave Coordinator

Supervisor/Designated Leave Coordinator: Maintain form in confidential department file; copy to Human Resources – Benefits

*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[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 the 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 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:
      (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. 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**[2] **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).

[2] "Incapacity," for purposes of the 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.

[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.