

Family and Medical Leave Request

(Family and Medical Leave Act of 1993)



To: _____
(Supervisor's Name – please print)

From: _____
(Employee's Name – please print)

EID: _____

Department : _____

Subject: **Family and Medical Leave**

I believe I meet the eligibility¹ requirements of the Family and Medical Leave Act (FMLA) and I am therefore requesting a FMLA leave for the following qualifying reason:

- A **serious health condition** that makes me unable to perform the essential functions of my job;
- A **serious health condition** affecting 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*), for which I am needed to provide care;
- The birth of my child and the care of such newborn child; or
- The placement of a child with me for adoption or foster care.

If you have indicated the leave is for a **serious health condition** above, please review the definition of a serious health condition on page 2 and check the applicable category of serious health condition below:

- | | |
|---|---|
| <input type="checkbox"/> Hospital Care | <input type="checkbox"/> Absence Plus Treatment |
| <input type="checkbox"/> Pregnancy | <input type="checkbox"/> Chronic Conditions Requiring Treatments |
| <input type="checkbox"/> Permanent/Long-term Conditions Requiring Supervision | <input type="checkbox"/> Multiple Treatments (Non-Chronic Conditions) |

You may be required to furnish medical certification of a serious health condition if requested to do so by your immediate supervisor or other responsible administrator.

I am requesting leave beginning on _____ (*insert specific date*) and I expect leave to continue until on or about _____ (*insert specific date*) as a continuous **intermittent** **reduced work schedule** leave.

If you have indicated it will be necessary for you take leave 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. See Classified Staff Policy #218.0 or University Handbook for Appointed Personnel Policy #8.04.06 for definitions and further information.

Family and Medical Leave Request

Page 2 of 2

I understand that I am required* to use my accrued sick leave for this FMLA leave and if I should exhaust my sick leave, I do do not elect to use my accrued vacation in lieu of an unpaid absence.

* If you are receiving benefit payments for worker's compensation then use of accrued sick leave and/or vacation is optional and the total of all such payments cannot exceed your gross earnings. Check your election (optional) sick vacation

Eligible employees have a right under the FMLA for up to 12 weeks of unpaid leave in a 12-month rolling calendar year (measured backward from the date the proposed leave is to begin) for the qualifying reasons listed on page 1. Also, your health benefits must be maintained during any period of unpaid leave under the same conditions as if you continued to work, and you must be reinstated to the same or an equivalent job with the same pay, benefits, and terms and conditions of employment on your return from leave. If you do not return to work following FMLA leave for a reason other than: (1) the continuation, recurrence, or onset of a serious health condition which would entitle you to FMLA leave; or (2) other circumstances beyond your control, you may be required to reimburse the University of Arizona for the employer's share of health insurance premiums paid on your behalf during your FMLA leave.

Employee Signature: _____ 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 incapacity² or subsequent treatment in connection with or consequent to such inpatient care.
2. Absence Plus Treatment
(a) A period of incapacity² of **more than three consecutive calendar days** (including any subsequent treatment or period of incapacity² 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 incapacity² (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 incapacity² 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.