UNIVERSITY OF DAYTON
APPLICATION FOR FAMILY & MEDICAL LEAVE, MILITARY OR PERSONAL LEAVE OF ABSENCE
EMPLOYEES & SUPERVISORS MUST REVIEW INSTRUCTIONS ON NEXT PAGE

NAME ______________________________UD ID NUMBER_______________________DEPARTMENT_______________________

I. TYPE OF LEAVE DESIGNATION (Please check the appropriate box)	**With Pay**	**Period of Absence (Dates)**	**Without Pay**	**Period of Absence (Dates)**
FAMILY & MEDICAL LEAVE: (As covered by the Family & Medical Leave Act- see appropriate employee handbook)				
☐ Employee's serious medical condition	☐	from______to_______	☐	from______to_______
Is this leave request related to an injury filed under Workers' Compensation? ☐Yes ☐ No				
☐ To care for spouse, child or parent with a serious medical condition	☐	from______to_______	☐	from______to_______
☐ Birth of a child and/or to care for a newborn child	☐	from______to_______	☐	from______to_______
☐ Adoption or foster care of child	☐	from______to_______	☐	from______to_______
MILITARY:				
☐ Military Assignment	☐	from______to_______	☐	from______to_______
PERSONAL:				
☐ Sabbatical	☐	from______to_______	☐	from______to_______
☐ Other (please specify)________________________	☐	from______to_______	☐	from______to_______

Explanation/Comments:____
____

II. SICK LEAVE AND VACATION BALANCES (Note: Accrued sick leave must be used for an employee's time off work due to his/her personal illness or medical condition for the period of time indicated by the employee's physician on the University's Medical Certification Form.)

Paid Medical Time Off/Salary Continuation balance: ______________________________ as of ___________________
(Please indicate hours/days/ months) (Date)

Vacation balance: ____ as of _________________
(Please indicate hours/days) (Date)

III. CERTIFICATION AND APPROVAL
I certify that the above statements are true and understand that falsification of either this signed statement or the physician's certificate shall be grounds for disciplinary action including dismissal. I am aware of the leave of absence information and instructions on the next page as well as the University's policy on leaves of absence in the appropriate employee handbook.

____ ____________________
(Signature of Employee) (Date)

***** Departmental signatures are only required for personal leaves and sabbaticals.***

( ) Approve ( ) Disapprove ____ ____________________
(Immediate Supervisor) (Date)

( ) Approve ( ) Disapprove ____ ____________________
(Department Head/Chairperson) (Date)

( ) Approve ( ) Disapprove ____ _____________________
(Dean/VP) (Date)

( ) Approve ( ) Disapprove ____ _____________________
(Provost) (Date)

TO BE COMPLETED BY THE OFFICE OF HUMAN RESOURCES ONLY:

The above request for leave of absence is approved ☐ disapproved ☐. This leave is ☐ is not ☐ being designated as Family & Medical Leave.
Comments: ____
____

Signed by: ______________________________________ _________________
(Office of Human Resources) (Date)

INSTRUCTIONS FOR COMPLETING APPLICATION FOR LEAVE OF ABSENCE

A. This form must be submitted to the office of human resources for Family and Medical Leave requests or to your immediate supervisor and/or department head for personal leaves in sufficient time prior to the date of leave requested so that appropriate consideration may be given to the request.

B. Attach or provide any information that may be appropriate to substantiate the request for the leave:

   a. Family and Medical Leave: The University of Dayton Medical Certification Form **MUST** be completed by the attending healthcare provider and submitted together with the Application for Leave of Absence directly to the office of human resources either via mail to campus zip +1649 or on the 3rd floor of St. Mary's Hall. All medical information will be kept confidential and maintained in a separate file in the office of human resources. When any such leave of absence expires and an extension is necessary, an updated Medical Certification Form from the healthcare provider and a new Application for Leave of Absence must be submitted to the office of human resources for consideration. Please refer to the Family & Medical Leave Act policy in addition to the Leave of Absence policy in the appropriate Benefit Handbook. Requests for intermittent leave must also be submitted using this paperwork.

   b. Military: A statement from the military fiscal officer or a copy of the military orders. Proof of pay during military leave must also be submitted in order for consideration to be given for payment of differential in pay. Please refer to the Military Leave policy in the appropriate Benefit Handbook.

   c. Personal/Other: A request must be made in writing using the Application for Leave of Absence with the reason for the leave. In some cases, written verification must be provided from the appropriate sources(s). For educational/sabbatical, a statement as to degree sought, institution where study will be undertaken, or any other appropriate information and/or verification as requested by the University must be provided. Such leaves may be granted on a case by case basis without pay but generally will require the employee to have completed one year of service before being considered. Please refer to the Leave section of the appropriate Benefit Handbook.

C. For personal leaves, after all documents have been reviewed and the Application for Leave of Absence has been signed by the appropriate persons, the department head/chairperson will forward them to the office of human resources for final consideration.

The department/division is strictly prohibited from copying and/or retaining any medical information including the Medical Certification Form. All medical information must be immediately forwarded to the office of human resources.

   a. In the case of a faculty member, all non-medical documents will be forwarded to the dean and provost accordingly and then to the office of human resources for consideration.

IMPORTANT: To ensure continuation of University benefits, you must contact the office of human resources **before** beginning a leave of absence.

THE UNIVERSITY OF DAYTON MEDICAL CERTIFICATION FORM
(*To be completed by attending physician)*
Family & Medical Leave Act of 1993

ALL INFORMATION PROVIDED ON THIS FORM BY THE EMPLOYEE AND HIS/HER PHYSICIAN(S) IS CONFIDENTIAL AND PHOTOCOPYING OF THIS INFORMATION IS STRICTLY PROHIBITED. 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 do 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's genetic tests, 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. Employee's Name: ____

2. Patient's Name (if different from employee): __________________________Relationship to employee:_______________

3. Please identify which Family & Medical Leave category under which the patient's condition qualifies. (See end of this certification for a list of qualifying conditions)
(1) ____ (2) ____ (3) ____ (4) ____ (5) ____ (6) ____ or None of the conditions listed _____

4. Describe the medical facts which support your certification, including a brief statement as to how the medical facts meet the criteria of one of these categories: ____
____

5a. State the approximate date the condition commenced _______________

5b. State the probable or estimated duration of the condition and the probable duration of the incapacity if different____

5c. Will it be necessary for the employee to work only intermittently or to work on a less than full schedule as a result of the condition (including for treatment described in question #6 below)? __________________________________

5d. If the condition is a chronic condition (condition #4) or pregnancy, state whether the patient is presently incapacitated____

5e. If the answer to 5d above is yes, state the probable or estimated duration of the incapacity ______________________

5f. If the answer to 5d above is yes, state the frequency and duration of such periods of incapacity
____

6a. If additional treatments will be required for the condition, provide an estimate of the probable number of such treatments ____

6b. 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 of the probable number and interval between such treatments______________________

6b1. Actual or estimated dates of treatment if known ____________________________________

6b2. Period required for recovery____

6c. If any of these treatments will be provided by another health care provider (e.g. physical therapist), please state the nature of such treatments____

6d. If a regimen of continuing treatment by the patient is required under your supervision, provide a general description of such regimen (e.g. Rx drugs, physical therapy requiring special equipment)______________________________
____

7a. If medical leave is required for the employee's absence from work because of the employee's own condition (including absence due to pregnancy or chronic condition), is the employee unable to perform work of any kind? ________________

7b. If able to perform some work, is the employee unable to perform any one or more of the essential functions of his/her job (the employee should supply you with information regarding essential job functions) ___________________________

7c. If the answer to 7b is yes, please list the essential functions that the employee is unable to perform_______________
____

7d. If neither 7b or 7c apply, is it necessary for the employee to be absent from work for treatment __________________

*****Signature of health care provider required on next page.***

TO BE COMPLETED FOR LEAVES FOR QUALIFYING FAMILY MEMBERS ONLY:

8a. If leave is required to be taken to care for a qualifying family member, does the patient require assistance for basic medical or personal needs, safety or transportation? ____

8b. If no, would the employee's presence to provide psychological comfort be beneficial to the patient or assist in the patient's recovery? ____

8c. If the patient will need care only intermittently or on a part-time basis, indicate the probable duration of the need _____ ____

8d. If the patient will need care only intermittently or on a part-time basis, indicate the number of times per month that the employee's assistance will be required ____

*****Signatures required for all applications involving medical leaves.***

______________________________ (Signature of health care provider)

______________________________ (Type of practice)

__________________________ (Phone number)

______________________________ (Print name of health care provider)

____ (Address of health care practice)

________________ (Date)

A "Serious Health Condition" as defined by the Family and Medical Leave Act, means an illness, injury, impairment, 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. A period of incapacity of more than three consecutive calendar days (including any subsequent treatment or period of incapacity relating to the same condition) that also involves:
      i. 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
      ii. 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 Treatment
   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 underlying condition); and
   c. May cause episodic rather than continuing period of incapacity (e.g. asthma, diabetes, epilepsy, etc.)

5. Permanent/Long Term Condition 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 not need to be receiving active treatment by a health care provider. Examples include Alzheimer's, severe stroke or the terminal stages of a disease.

6. Multiple Treatments (Non-chronic Conditions)
   A period of absence to receive multiple treatments (including any period of recovery from) by a health care provider or by a provider of health care services under order 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), kidney disease (dialysis).

* 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.
** A regimen of continuing treatment includes, for example, a course of Rx 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, nor does it include bed rest, drinking fluids, exercise and other similar activities that can be initiated without a visit to a health care provider.