UNIVERSITY OF LOUISVILLE.

REQUEST FOR TEMPORARY MEDICAL LEAVE OF ABSENCE

Instructions for Section I

Human Resources is responsible for handling requests for Temporary Medical Leave (TML) under PER 4.13. Under the policy, employees who are unable to return to work after their Family and Medical Leave (FML) has exhausted, may request Temporary Medical Leave for a period of up to three months. TML is continuous leave without pay for the employee; an eligible employee must use all applicable accrued paid leave balances (including sick, vacation, and personal leave) while taking TML.

Please fully answer each item in Section I, then have your supervisor and department head sign the acknowledgement portion. Following completion of Section I, submit the form to your healthcare provider to complete Section II. Forward completed forms and attachments to Human Resources, 215 Central Ave., suite 205 Louisville, Kentucky 40208, e-mail to leaveadm@louisville.edu, or fax to (502) 852-2019.

UofL requires you to submit a timely, complete and sufficient medical certification to support a request for temporary medical leave. Failure to provide a complete and sufficient medical certification will result in a denial of your request. **Requests for information must be fulfilled within fifteen (15) calendar days.**

Section I: For Completion by Employee

Last Name: _____ First Name: _____

Mailing Address: _____

City: _____ State: _____ Zip Code: _____

E-mail: _____ Home/Mobile Phone: _____

UofL ID#: _____ Department: _____

Name of Department Timekeeper/UBM: _____

DEPARTMENT ACKNOWLEDGEMENT

I acknowledge that this employee has notified me that they are seeking approval of TML with Human Resources.

Supervisor Name and Signature: _____ Date: _____

Dept. Head Name and Signature: _____ Date: _____

EMPLOYEE AUTHORIZATION

I give UofL permission to explore necessary information from my department and/or health care provider in order to process this request, and acknowledge that such communication is job-related and consistent with business necessity. I understand that all information obtained during this process will be maintained and used in accordance with confidentiality requirements.

Print Name of Employee: _____

Signature of Employee: _____ Date: _____

Instructions for Section II

Your patient has requested temporary medical leave. Please fully answer each applicable item in this section. The employee should provide you with a copy of their job functions. Several questions seek a response as to the frequency or duration of a condition, treatment, etc.; your answer should be your best estimate based upon your medical knowledge, experience, and examination of the patient. Please limit responses to the condition for which the employee is seeking leave. Do not provide information about genetic tests, genetic services, or the manifestation of disease or disorder in the employee's family members.

Section II: For Completion by Healthcare Provider

Healthcare Provider's Name: _____

Mailing Address: _____

City: _____ State: _____ Zip Code: _____

Phone Number: _____ Fax Number: _____

Type of practice/medical specialty: _____

Patient Medical Facts

Employee (Patient) Name: _____

Date condition commenced: _____ Probable duration of condition: _____

Was the patient admitted for an overnight stay in a hospital, hospice, or residential medical care facility? ◯ Yes ◯ No

If yes, dates of admission: _____

Date(s) you treated the patient for condition: _____

Will the patient need to have treatment visits at least twice per year due to the condition? ◯ Yes ◯ No

Was medication, other than over-the-counter medication, prescribed? ◯ Yes ◯ No

Was the patient referred to other health care provider(s) for evaluation or treatment? ◯ Yes ◯ No

If yes, state the nature of such treatments and expected duration of treatment:

Is the medical condition pregnancy? ◯ Yes (Expected Delivery Date: _____) ◯ No

Is the employee unable to perform any of his/her job functions due to the condition? ◯ Yes ◯ No

If yes, state the job functions the employee is unable to perform:

Amount of Leave Needed

1) Will the employee be incapacitated for a single continuous period of time due to his/her medical condition, including any time for treatment and recovery?

Yes No

If yes, estimate the beginning and ending dates of incapacity: _____ through _____

2) Will the employee need to attend follow-up treatment appointments or work part-time or on a reduced schedule because of the employee's medical condition?

Yes No

If yes, are the treatments/reduced number of hours of work medically necessary? Yes No

Estimate the treatment schedule, if any, including the dates of any scheduled appointments and the time required for each appointment, including any recovery period:

Estimate the part-time or reduced work schedule the employee needs, if any:

_____ hour(s) per day; _____ days per week from _____ through _____

3) Will the condition cause episodic flare-ups periodically preventing the employee from performing his/her job functions?

Yes No

Is it medically necessary for employee to be absent from work during flare-ups? Yes No

If yes, please explain:

_____

Based upon the patient's medical history and your knowledge of the medical condition, estimate the frequency of flare-ups and the duration of related incapacity that the patient may have over the next 6 months:

Frequency: _____ time(s) per _____ week(s) _____month(s)

Duration: _____ hour(s) or _____ day(s) per episode

Any additional information:

Signature of Health Care Provider: _____ Date: _____

For University Use Only: Date Form Received:_____ Signature: _____