



Family & Medical Leave Action Request Form

Important Employee Information Checklist

- 1. Make **two copies** of the **completed form**. Keep one copy for yourself, give one copy to your manager and send the original form to HR Employee Relations.
- 2. All new applications for FMLA leave must be submitted thirty days (30) prior to leave. FMLA leave will not be approved retroactively except in the event of a medical emergency. In the event of an emergency, the employee or employee's designee must submit this form as soon as possible or within two (2) days after return to work in order to be considered for retroactive FMLA coverage.
- 3. Requests for **intermittent FMLA leave** will require recertification promptly at 90-day intervals. Failure to provide timely recertification will result in absences not covered by the Family and Medical Leave Act.
- 4. FMLA Action Request Forms can be submitted in person during regular business hours to the HR Employee Relations office, 7th floor Anderson Annex. Forms may also be submitted via interoffice mail or mailed to HR Employee Relations, UNC Health Care, 101 Manning Drive, Chapel Hill, NC 27514. Applications received in person or by mail will be date stamped upon receipt. Request forms may also be faxed to (919) 966-1005; however the original should still be submitted to HR Employee Relations.
- 5. **Don't forget to sign the last page.** Both the employee's signature and physician's signature are required.
- 6. Available benefit time will be utilized during any FMLA absence. Refer to Chapter 9 of the Human Resources Management Policies and Procedures Manual for clarification regarding use of benefit accruals.
- 7. If you are approved for FMLA leave, any hours used for this purpose (whether paid or unpaid) are deducted from the 12-week maximum allowance. The 12 month clock starts on the first day any FMLA leave is certified.

Note: Any FMLA leave already taken in the last 12 months is deducted from the 12-week maximum allowance. It is both the employee and supervisor's responsibility to track the total amount of Family & Medical Leave used.

**INCOMPLETE FORMS WILL NOT PROCEED TO THE
FMLA COMMITTEE.**



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Section A – Eligibility - to be completed by the Employee

1. Have you been a permanent UNC Health Care employee for 1 year and worked at least 1040 hours in the last 12 months? [] Yes [] No

If you answered No above, you are NOT eligible for FMLA leave.

2. Mark the reason(s) for Family & Medical Leave:

- [] Personal serious health condition [] Birth of child
[] Care for child (under 18) with serious health condition: ____ Age [] Care for child after birth
[] Care for parent or spouse with serious health condition [] Adoption; foster care
[] Care for child (18 or over) that is incapable of self-care because of a permanent mental or physical disability
[] Family member who is a military servicemember on active duty or notified of an impending call or order to active duty.
[] Family member who is a military servicemember with a serious injury or illness.

You are NOT eligible for Family & Medical Leave if your request for leave is for a reason other than one listed above.

Continue to Section B.

Section B – Employee Data - to be completed by the Employee

Form with fields: First Name, M.I., Last Name, EID, Employee telephone /Pager #, Supervisor's Name (Please Print), Supervisor's telephone/Pager #, Employee Home phone #, Committee letter to be sent to: [] Home address* [] Work address [] Work e-mail, Job Title, Department, *Give Home address: (street), (City, State, Zip), Regular shift assignment – hours/day and days/week (Please be specific), Type of appointment – Please Check one: [] FT [] PT, Expected leave start date, Expected date of return to work.

Continue to Section C.

For UNC Health Care's Family & Medical Leave Committee Use Only

Form with fields: EOD: _____ Committee Comments: _____
[] Approved Date approved: _____ [] Denied _____
Date letter sent: _____



Family & Medical Leave Action Request Form

Section C: Certification of Health Care Provider - To be completed by physician/health care provider

1.	Employee's name _____
2.	Patient's name (if different from employee): _____ Relationship to employee? <input type="checkbox"/> Parent (in-laws not permitted) <input type="checkbox"/> Spouse <input type="checkbox"/> Child
3.	Does the patient's condition meet any of the following criteria? If so, please indicate the applicable categories below by marking an "X" next to number.
___	3.1 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.
___	3.2 Incapacity* Plus Continuing Treatment A period of incapacity of more than three consecutive days (including any subsequent treatment 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 order 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.
___	3.3 Pregnancy Any Period of incapacity due to pregnancy or for prenatal care
___	3.4 Incapacity* or treatment for incapacity due to Chronic Serious Health Condition A Chronic Serious Health Condition is one 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; and b. Continues over an extended period of time (including recurring episodes of a single underlying condition; and c. May cause episodic rather than a continuing period of incapacity (e.g., asthma, diabetes, epilepsy, etc).
___	3.5 Permanent/long-term incapacity 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 (e.g., Alzheimer's, a severe stroke, or the terminal stages of a disease).
___	3.6 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 3 consecutive calendar days in the absence of medical intervention or treatment, such as cancer (chemotherapy, radiation, etc.), severe arthritis (physical therapy), or kidney disease (dialysis).
___	3.7 None of the above (3.1 – 3.6)
* Definition of Incapacity: the inability to work, attend school or perform other regular daily activities due to the serious health condition, treatment therefore, or recovery therefrom.	



Family & Medical Leave Action Request Form

4. Describe the medical facts that support your certification, including a brief statement as to how the medical facts meet the criteria of the category(s) you have selected above.
5. *If patient is not employee, continue to question 12 on last page.*
State the approximate date the patient's health condition did/will commence: _____
The probable duration of the condition: _____
The probable duration of the patient's incapacity if different from condition: _____
6. Is **intermittent leave** (i.e., leave that is episodic or occasional) or a reduced work schedule **required** as a result of the patient's health condition?
____ **No**
____ **Yes, intermittent leave is required; and**
The employee will **likely be absent** _____ days in the next 90 days.
____ **Yes, a reduced work schedule is required; and**
The employee will need **to work only** _____ hours per day for _____ weeks.
7. If the condition is chronic or a pregnancy, is the patient presently incapacitated?
____ No
____ Yes, the patient is presently incapacitated; and
The likely duration and frequency of episodes of incapacity are: _____
8. Is the employee able or unable to perform work? Please mark the appropriate response.
____ The employee **is able** to perform his/her work.
____ The employee **cannot perform one or more of the essential job functions** listed below (the requesting employee of UNC Health Care is responsible for providing a job description or other information about the essential job functions):

____ The employee **cannot** perform work of any kind.
9. Are additional treatments required for the serious health condition?
____ No ____ Yes
If yes, please indicate the frequency and duration of the treatment plan in question 10 below if treatment is to occur or is required to be scheduled during regular work hours.
10. Is it necessary for the employee to be absent from work for treatment?
____ No
____ Yes, and the patient will likely require _____ treatments in the next 90 days.
Such treatments will likely require _____ hour(s) per day.
Such treatments will likely require _____ hour(s) per day for recovery after treatment.
Please provide actual or estimated dates of treatment if known and estimated period required for recovery after treatment if any:

Family & Medical Leave Action Request Form

11. If a regimen of continuing treatment by the patient is required under your supervision, provide a general description of that regimen (e.g., prescription drugs, physical therapy requiring special equipment):

Complete items 12 – 14 only if FMLA leave is required for family member:

12. Does the patient (employee’s family member) require assistance for basic medical or personal needs or safety, or for transportation?

Yes No

13. Would the employee’s presence to provide **psychological comfort** be beneficial to the patient or assist in the patient’s recovery?

Yes No

14. Will the patient need care intermittently (i.e., occasionally or episodically) or on a part-time basis?

No

Yes, intermittent care is required; and to provide assistance and support,

The employee will likely be absent _____ days in the next 90 days.

Print Name of Health Care Provider

Date signed

Signature of Health Care Provider

Type of Practice

Address

Telephone Number

I request approval for FMLA leave, and I give UNC Health Care permission to contact my Health Care Provider *if clarification is required regarding any of the information above relating only to the medical condition for which FMLA Leave is requested.*

Employee Signature

Date