

APPLICATION FOR NON-FMLA MEDICAL LEAVE

College

An employee who may not be eligible for FMLA Leave may apply for Non-FMLA Medical leave. The employee must complete this form, include the Healthcare Provider Certification, and submit to Human Resources.

Employee Information:

Date of submission Name Empl. ID
Contract Title Department
Contact information while on leave Home Phone Cell Phone Email _____
Supervisor's Name Phone

TO BE COMPLETED BY HEALTH CARE PROVIDER

PRINT CLEARLY OR TYPE

Approximate date condition commenced _____ Medical condition is due to pregnancy
Date(s) of treatment(s) _____ Expected delivery date _____

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

If yes, identify the job functions the employee is unable to perform: *(Refer to Essential Functions listed in the job description provided by the employer, or as based upon the employee's own description of his/her job):*

Describe other relevant medical facts, if any, related to the condition for which the employee seeks leave (such medical facts may include symptoms, diagnosis, or any regimen of continuing treatment, such as the use of specialized equipment):

Period of incapacity: Begin Date _____ End Date _____

Estimated date when employee will be able to return to full, unrestricted duty _____

HEALTH CARE PROVIDER'S CERTIFICATION

I certify that the above facts are true and correct.

Signature _____ Date _____

Print Name _____ License Number _____

Address _____

City _____ State _____ Zip Code _____ Phone _____ FAX _____

Type of Practice _____

NON-FMLA MEDICAL LEAVE - DESIGNATION NOTICE

College Date

To: Name Empl. ID

C: Supervisor's Name

We have received your application for **NON-FMLA Medical Leave**, along with the supporting documents dated

Based on the information you have provided to date, the following breakdown of leaves will be recorded:

- Type of Leave Start Date End Date

Anticipated date of return **Actual Date of Return** _____

Fitness for Duty Certification

- You will be required to present a Fitness for Duty Certification prior to being restored to employment. If such certification is not received in a timely manner, your return to work may be delayed until such certification is provided.
- The Fitness for Duty Certification must address your ability to perform the functions of your job. Refer to Essential Functions listed in the Job Description provided by the employer, or as based upon the employee's own description of his/her job.
- You will **NOT** be required to present a Fitness for Duty Certification prior to being restored to employment.

Additional information is required to determine if your Application for Non-FMLA Medical Leave can be approved

- The certification you provided is not complete and sufficient. You must provide the following information no later than the date specified, unless it is not practicable under the particular circumstances despite your diligent good faith efforts, or your leave may be denied. Date

Information needed to make the certification complete and sufficient:

TO BE COMPLETED BY HUMAN RESOURCES

Leave with Pay ends _____ Health Coverage ends _____ COBRA begins, if applicable _____

Date (s) of Special Leave of Absence Coverage (SLOAC) From _____ To _____

This form must be signed by the Director of Human Resources or Designee:

Name Signature _____

Date _____

FITNESS FOR DUTY CERTIFICATION

College

An employee on Non-FMLA Medical Leave of Absence because of his/her own serious medical condition must present this certification to the Human Resources Department prior to or on the day he/she returns to work.

Supervisors are advised to forward any forms submitted directly to them to the Human Resources Department.

An employee may not work without this certification. If you are on unpaid leave, Human Resources will place you back on the payroll ONLY upon receipt of this form.

Employee Information:

Name Empl. ID

Contract Title Department

Contact information while on leave Home Phone Cell Phone Email

To: Health Care Provider

The employee noted above began a period of medical care leave for his /her own serious health condition on Date

As a condition to return to work, the employee must have a health care provider certify that the employee is medically fit to resume his/her job duties.

Date employee may return to work _____

Employee may return to work with full, unrestricted duty

Employee may return to work with modified duty Explain _____

If the employee is being released to modified duty, please complete the following:

Estimated date when employee will be able to return to full, unrestricted duty _____

Date of next medical evaluation of the employee _____

HEALTH CARE PROVIDER'S CERTIFICATION

I certify that the above facts are true and correct.

Signature _____ Date _____

Print Name _____ Phone Number _____

Address _____

City _____ State _____ Zip Code _____

Type of Practice _____ License Number _____

RECEIVED BY (This form must be signed by the Director of Human Resources or Designee)

Signature _____ Date _____