



Family And Medical Leave Act (Request for Leave/Notice of Leave)

Instructions

1. Request for leave under the Family and Medical Leave Act must be submitted **30** days in advance if the need is foreseeable. If not, the Request for Leave/Notice must be submitted as soon as practicable.
2. **Medical Certification:** If you request leave to care for a sick family member or because of your own serious health condition, you must supply to Human Resources, with **15** calendar days after your request, a medical certification on the form attached. The certification must be completed by a doctor or medical practitioner.
3. Complete and sign the form. Attach leave slips for duration of leave.
4. Forward forms and attachments to the Human Resources Department.
5. You will be notified by Human Resources whether your leave has been approved.

Employee Name

Social Security Number

Department Name

Work Phone Number

Actual/Anticipated Dates of Leave: _____ to _____.

Reason for Leave (mark only one):

- Birth of child or to care for newborn child. Actual/anticipated date of birth: _____.
- Placement of child for adoption or foster care. Actual/anticipated date of birth: _____.
- To care for your spouse, child, or parent with a serious health condition (must provide completed Certificate of Physician or Practitioner to Human Resources).
- A serious health condition makes you unable to work (must provide completed Certification of Physician or Practitioner to Human Resources).
- Leave is requested on an intermittent or reduced leave basis.

- I hereby certify that all of the statements contained herein and attached are true to the best of my knowledge. I understand that omissions or misstatements may be cause for rejection of my leave request and disciplinary action by Coconino Community College.
- I also understand Coconino Community College may recover from me its portion of the health insurance premium paid during my leave if I fail to return to work for a reason other than continuation, recurrence, or onset of a serious health condition affecting myself or immediate family member.

Employee Signature

Date

Human Resources Signature

Date



Certification of Physician or Practitioner
(Family and Medical Leave Act of 1993)

To be completed by Physician or Practitioner:

- 1. Employee's Name:
2. Patient's Name (if other than employee):
3. Diagnosis:
4. Date Condition Commenced:
5. Probable Duration of Condition:
6. Regimen of treatment to be prescribed (indicate number of visits, general nature and duration of treatment, including referral to other providers of health services. Include schedule of visits or treatment if it is medically necessary for the employee to be off work on an intermittent basis or to work less than the employee's normal schedule of hours per day or days per week).

number of visits by Physician/Practitioner number of visits by other Provider of health services (if referred by Physician or Practitioner)

Check Yes or No in the boxes below.

- 7. Yes No Is employee able to perform work of any kind? (If "No", skip to item 8).
8. Yes No Is employee able to perform the functions of employee's position? (Answer after reviewing statement from employer of essential functions of employee's position, or, if none is provided, after discussing with employee.)
9. Yes No Does (or will) the patient require assistance for basic medical, hygiene, nutritional needs, safety or transportation?
10. Yes No After review of the employee's signed statement (see item 12 below), is the employee's presence necessary or would it be beneficial for the care of the patient? (This may include psychological comfort.)
11. Estimate the period of time care is needed or the employee's presence would be beneficial:
12. If Family Leave is needed to care for a seriously ill family member, the employee shall state the care he or she will provide and an estimate of the time period during which this care will be provided, including a schedule if leave is to be taken intermittently or on a reduced leave schedule. (Please complete on a separate piece of paper and attach.)

Physician or Practitioner Signature Date
Type of Practice (field of specialization if any)
Employee Signature Date