# FAMILY AND MEDICAL LEAVE Information Sheet
University of Arkansas Fayetteville

<table>
<thead>
<tr>
<th>Employee Name (Last, First)</th>
<th>Date (mm/dd/yy)</th>
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<tr>
<th>Employee I.D. Number</th>
<th>Department</th>
<th>Faculty/Staff (Choose One)</th>
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<tr>
<th>Supervisor Name</th>
<th>Employee Job Title</th>
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<th>Timekeeper Name</th>
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<tr>
<th>Requested FMLA Begin Date (mm/dd/yy)</th>
<th>Requested FMLA End Date (mm/dd/yy)</th>
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**AUTHORIZATION (to be completed by HR personnel only):**

Eligibility:

- Employed 12 mo? □ Yes □ No
- 1,250 hrs worked? □ Yes □ No

- Date of Hire: __________
- Hours worked: __________

- □ Approved
- □ Disapproved

- FMLA type: □ Personal □ Maternity/Paternity □ Family

- FMLA category: □ Intermittent
  - Parameters: __________________________
  - Continuous
  - Dates: _______________

- Fitness for Duty? □ Yes □ No

- Approving Authority: __________________________

- Date: _______________

For office use only: (check box once completed)

- □ Rights & Responsibilities Notice
- □ Designation Notice
- □ Approval Letter
- □ Fitness for Duty Form (if applicable)
- □ Exhaustion Letter
- □ Email to department

Revised 12/2019
SECTION I: For Completion by the EMPLOYER
INSTRUCTIONS to the EMPLOYER: The Family and Medical Leave Act (FMLA) provides that an employer may require an employee seeking FMLA protections because of a need for leave due to a serious health condition to submit a medical certification issued by the employee’s health care provider. Please complete Section I before giving this form to your employee. Your response is voluntary. While you are not required to use this form, you may not ask the employee to provide more information than allowed under the FMLA regulations, 29 C.F.R. §§ 825.306-825.308. Employers must generally maintain records and documents relating to medical certifications, recertifications, or medical histories of employees created for FMLA purposes as confidential medical records in separate files/records from the usual personnel files and in accordance with 29 C.F.R. § 1630.14(c)(1), if the Americans with Disabilities Act applies, and in accordance with 29 C.F.R. § 1635.9, if the Genetic Information Nondiscrimination Act applies.

Employer name and contact: __ University of Arkansas, Fayetteville; Katherine Moore, 479-575-3717 (office) 479-575-6971 (fax)

Employee’s job title: _________________________________ Regular work schedule: 8A - 5P

Employee’s essential job functions: __________________________________________________________

____________________________________________

Check if job description is attached: ____

SECTION II: For Completion by the EMPLOYEE
INSTRUCTIONS to the EMPLOYEE: Please complete Section II before giving this form to your medical provider. The FMLA permits an employer to require that you submit a timely, complete, and sufficient medical certification to support a request for FMLA leave due to your own serious health condition. If requested by your employer, your response is required to obtain or retain the benefit of FMLA protections. 29 U.S.C. §§ 2613, 2614(c)(3). Failure to provide a complete and sufficient medical certification may result in a denial of your FMLA request. 29 C.F.R. § 825.313. Your employer must give you at least 15 calendar days to return this form. 29 C.F.R. § 825.305(b).

Your name: ____________________________

First     Middle     Last

SECTION III: For Completion by the HEALTH CARE PROVIDER
INSTRUCTIONS to the HEALTH CARE PROVIDER: Your patient has requested leave under the FMLA. Answer, fully and completely, all applicable parts. 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. Be as specific as you can; terms such as “lifetime,” “unknown,” or “indeterminate” may not be sufficient to determine FMLA coverage. Limit your responses to the condition for which the employee is seeking leave. Do not provide information about genetic tests, as defined in 29 C.F.R. § 1635.3(f), genetic services, as defined in 29 C.F.R. § 1635.3(e), or the manifestation of disease or disorder in the employee’s family members, 29 C.F.R. § 1635.3(b). Please be sure to sign the form on the last page.

Provider’s name and business address: __________________________________________________________

Type of practice / Medical specialty: __________________________________________________________

Telephone: (______)___________________________ Fax:(______)___________________________
PART A: MEDICAL FACTS

1. Approximate date condition commenced: _____________________________________________

   Probable duration of condition: _____________________________________________________

Mark below as applicable:
Was the patient admitted for an overnight stay in a hospital, hospice, or residential medical care facility?  
___No  ___Yes. If so, 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?  ___No  ___Yes.

Was medication, other than over-the-counter medication, prescribed?  ___No  ___Yes.

Was the patient referred to other health care provider(s) for evaluation or treatment (e.g., physical therapist)?  
___No  ___Yes. If so, state the nature of such treatments and expected duration of treatment:

__________________________________________________________________________________

2. Is the medical condition pregnancy?  ___No  ___Yes. If so, expected delivery date: ________________

3. Use the information provided by the employer in Section I to answer this question. If the employer fails to  
   provide a list of the employee’s essential functions or a job description, answer these questions based upon  
   the employee’s own description of his/her job functions.

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

   If so, identify the job functions the employee is unable to perform:

__________________________________________________________________________________

4. 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): 

__________________________________________________________________________________

__________________________________________________________________________________

__________________________________________________________________________________

__________________________________________________________________________________

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CONTINUED ON NEXT PAGE

Form WH-380-E Revised May 2015
PART B: AMOUNT OF LEAVE NEEDED
5. 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? ___No ___Yes.

If so, estimate the beginning and ending dates for the period of incapacity: ____________________________

6. 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? ___No ___Yes.

If so, are the treatments or the reduced number of hours of work medically necessary? ___No ___Yes.

Estimate 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 __________

7. Will the condition cause episodic flare-ups periodically preventing the employee from performing his/her job functions? ____No ____Yes. 

Is it medically necessary for the employee to be absent from work during the flare-ups? ____ No ____Yes. If so, 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 (e.g., 1 episode every 3 months lasting 1-2 days):

Frequency : _____ times per _____ week(s) _____ month(s)

Duration: _____ hours or ___ day(s) per episode

ADDITIONAL INFORMATION: IDENTIFY QUESTION NUMBER WITH YOUR ADDITIONAL ANSWER.
Signature of Health Care Provider            Date

PAPERWORK REDUCTION ACT NOTICE AND PUBLIC BURDEN STATEMENT
If submitted, it is mandatory for employers to retain a copy of this disclosure in their records for three years. 29 U.S.C. § 2616; 29 C.F.R. § 825.500. Persons are not required to respond to this collection of information unless it displays a currently valid OMB control number. The Department of Labor estimates that it will take an average of 20 minutes for respondents to complete this collection of information, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. If you have any comments regarding this burden estimate or any other aspect of this collection information, including suggestions for reducing this burden, send them to the Administrator, Wage and Hour Division, U.S. Department of Labor, Room S-3502, 200 Constitution Ave., NW, Washington, DC 20210. DO NOT SEND COMPLETED FORM TO THE DEPARTMENT OF LABOR; RETURN TO THE PATIENT.