REQUEST FOR MEDICAL LEAVE OF ABSENCE

SECTION I: For Completion by the EMPLOYEE

INSTRUCTIONS TO EMPLOYEE

- Any employee requesting a medical leave of absence for his/her own health condition, who does not qualify for FMLA leave and who has not requested leave in connection with an accommodation request form, must complete this form and submit it to the IHB for approval along with the medical portion to be completed by his/her health care provider.
- Medical leaves may be granted at the discretion of the IHB for a period of time to be determined by the IHB.
- An employee on an approved leave must return to duty or have been approved for an extension prior to the expiration date of their current leave or they may be considered off without authority and subject to discipline.
- It is the employee's responsibility to ensure that any/all paperwork is completed and submitted to the IHB within the appropriate timeframes to ensure that their absence is covered and avoid being off without authority.

INFORMATION ABOUT YOU

FIRST NAME: ______________________ LAST NAME: ________________________________

IHB ID# __________ DEPT ____________________ JOB TITLE ________________________

ESSENTIAL JOB FUNCTIONS____

_____ Check if job description is attached _____ Check if job is designated as safety sensitive

EMAIL ADDRESS ____________________________ PHONE NUMBER ___________________

ADDRESS ____

street city state zip

INFORMATION ABOUT YOUR REQUEST

REASON FOR MEDICAL LEAVE OF ABSENCE: Not eligible for FMLA ______ FMLA exhausted ______

Other (explain) ______________________________

BEGINNING DATE OF LEAVE _______________ ENDING DATE OF LEAVE _______________

DESCRIPTION OF REQUEST/NEED FOR LEAVE OF ABSENCE
(Please give a description of the illness/injury and why it is necessary that you be off work)

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IF NECESSARY, DO WE HAVE PERMISSION TO CONTACT YOUR PHYSICIAN REGARDING YOUR REQUEST? Yes _______ No _______

______________________________ ______________

Employee Signature Date

SECTION II: FOR COMPLETION BY EMPLOYEE'S HEALTH CARE PROVIDER

INSTRUCTIONS TO HEALTH CARE PROVIDER

- Your patient has requested a medical leave of absence. Please answer all applicable parts fully and completely.
- Your answers should be your best estimate based upon your medical knowledge, experience and examination of the patient.
- Please be as specific as you can and avoid terms such as "lifetime", "indeterminate" or "unknown" as these may not be sufficient to determine a medical leave qualification.
- Limit your responses to the condition for which the employee is seeking leave. Please sign and date the form on the last page.

PROVIDER INFORMATION

PROVIDER NAME: ______________________________
PRACTICE/FACILITY NAME: ______________________________
ADDRESS: ______________________________
PHONE: ____________________ FAX: ____________________
EMAIL ADDRESS: ______________________________

NAME AND CONTACT INFO Of SOMEONE WE CAN CONTACT WITH QUESTIONS REGARDING THIS FORM:

NAME: ______________________________
EMAIL ADDRESS: ______________________________
PHONE: ______________________________

MEDICAL FACTS

APPROXIMATE DATE CONDITION COMMENCED ______________________________
PROBABLE DURATION OF CONDITION ______________________________
EXPECTED RETURN TO WORK DATE ______________________________

WAS THE PATIENT ADMITTED FOR AN OVERNIGHT STAY IN A HOSPITAL, HOSPICE OR RESIDENTIAL MEDICAL CARE FACILITY AS A RESULT OF THIS CONDITION?
IF SO, LIST DATE(S) ______________________________

DATE(S) YOU TREATED THE PATIENT FOR THIS CONDITION ______________________________

WILL PATIENT NEED TO BE SEEN AT LEAST TWICE A YEAR DUE TO THIS CONDITION?
YES ____________ NO ____________

WHEN IS THE PATIENT'S NEXT SCHEDULED APPOINTMENT? ______________________________

WILL THE PATIENT HAVE ONGOING TREATMENT/THERAPY RELATED TO THIS CONDITION?
YES ____________ NO ____________

IF SO, PLEASE LIST THE NATURE OF THE TREATMENT/THERAPY AND EXPECTED FREQUENCY AND DURATION ______________________________
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DURING THE COURSE OF THIS TREATMENT, THE EMPLOYEE CAN WORK:
A FULL SCHEDULE __________ A REDUCED SCHEDULE __________ NO WORK __________

WERE ANY DRUGS, OTHER THAN OVER THE COUNTER, PRESCRIBED TO THE PATIENT?
YES ____________ NO ______________

IS THE EMPLOYEE UNABLE TO PERFORM ANY OF HIS/HER JOB FUNCTIONS DUE TO THIS CONDITION? YES ____________ NO ______________

IF YES, PLEASE LIST WHICH JOB FUNCTIONS THEY ARE UNABLE TO PERFORM

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(if you need a functional job description, please contact us and we will provide you with one)

PLEASE LIST ANY RELEVANT MEDICAL FACTS RELATED TO THE CONDITION FOR WHICH THE EMPLOYEE IS REQUESTING THIS LEAVE OF ABSENCE THAT WOULD ASSIST IN MAKING A DETERMINATION (SYMPTOMS, DIAGNOSES OR REGIMENT OF CONTINUING TREATMENT) ____

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AMOUNT OF LEAVE NEEDED

WILL THE EMPLOYEE BE INCAPACITATED FOR A SINGLE CONTINUOUS PERIOD OF TIME OR INTERMITTENTLY OVER A PERIOD OF TIME?
Single Continuous __________ Intermittment ___________

If single continuous, estimate the beginning and ending dates of incapacity:

____

If intermittent, estimate the expected frequency of need for time off:

____

IS IT NECESSARY FOR THE EMPLOYEE TO BE OFF WORK DUE TO THIS CONDITION OR ITS TREATMENT, OR IS WORKING A REDUCED SCHEDULE AN OPTION?
please explain ____

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ARE TREATMENTS OR REDUCED NUMBER OF HOURS MEDICALLY NECESSARY?
YES ____________ NO ______________

PLEASE DESCRIBE TREATMENT AND TREATMENT SCHEDULE FOR THIS CONDITION

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PLEASE LIST ANY ADDITIONAL INFORMATION YOU WOULD LIKE US TO HAVE REGARDING THIS PATIENT/CONDITION ____

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SIGNATURE OF PROVIDER ______________________________ DATE ____________

SECTION III: Our contact information

IF YOU HAVE ANY QUESTIONS REGARDING THIS FORM, PLEASE CONTACT US.
IF YOU NEED A COPY OF THE PATIENT'S FUNCTIONAL JOB DESCRIPTION TO ASSIST YOU IN FILLING OUT THIS FORM, PLEASE CONTACT US.

MANAGER HR/LR Phone 219-989-4850
Fax 219-989-4967
Email HR@ihbrr.com