



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 issue, 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.
Leave may be granted at the discretion of the IHB.
If leave is granted, it will be granted for a period of time to be determined by the IHB only.
Upon expiration of any approved leave, you must return to duty or have been approved for an extension prior to the expiration date of your current leave.
It is your responsibility to complete any/all paperwork within the appropriate timeframes to ensure that your 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)

IF NECESSARY, DO WE HAVE PERMISSION TO CONTACT YOUR PHYSICIAN REGARDING YOUR REQUEST?

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.
- Several questions seek a response as to the frequency and/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.
- 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 FOR 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 _____

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

(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) _____

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 _____

ARE TREATMENTS OR REDUCED NUMBER OF HOURS MEDICALLY NECESSARY?

YES _____ NO _____

PLEASE DESCRIBE TREATMENT AND TREATMENT SCHEDULE FOR THIS CONDITION

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

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