East Carolina University Family Illness Leave Application

| Part I: TO BE COMPLETED BY EMPLOYEE | |
|---|----------------------------------|
| 1a. Name | 2a. Dept |
| 1b. Banner ID 1c. | 2b. Supervisor |
| Home Phone | 2c. Supervisor's Campus Phone |
| 3. Reason for Requested Family Illness Leave (Please have patient's physician complete the Medical Certification Form and return to the Benefits Office.) Care for the serious health condition of my: Child Spouse Parent | |
| 4. Duration/Type of Leave | |
| 4a. Date Leave Begins | 4b. Anticipated Date of Return |
| This leave will be taken on a full-time basis This leave will be taken intermittently or on a Reduced schedule (If this box is checked, the applicant must provide the supervisor with a schedule, which must be approved by the supervisor) | 4c. Revised Date of Return |
| 5. Terms of Leave I understand that the designation of this leave as Family Illness Leave may be delayed until the appropriate medical certification is received by East Carolina University Benefits Office. If I have any sick or annual leave, I will complete the necessary leave forms designating which type of paid leave I wish to use to cover this period. I agree that while I am on leave, I will continue to pay my share of the health insurance premiums, if applicable, unless I elect to discontinue coverage. If I am unable to return to work because of my family member's serious health condition, I will provide medical certification from the appropriate health care provider stating that I needed to care for my spouse, child or parent because he/she had a serious health condition on the date that my leave expired. I also agree that I won't commence work for another employer while on leave. Finally, I understand that if I do not return to work on the date indicated above (or another date as specified by me and agreed to by the University), my employment may be terminated by the University as of the date my leave expired. | |
| Signed: Date: | |
| HR Form 9.1 (Reproducible) | Enclosure to PIM #9 |
| Revised 08/05 East Carolina University Human Resources, Benefits Office 210 East 1 st Street | |

Greenville, NC 27858

If you have questions call: (252) 328-9887

East Carolina University CERTIFICATION BY MEDICAL PRACTITIONER

Family Illness Leave

Please complete all items below. Attach additional pages, if necessary

| PART I: TO BE COMPLETED BY EMPLOYEE (Please print or type) | |
|--|-------------------------------------|
| 1. Employee Name: | 2. Banner ID: |
| 3. Patient's Name: | 4. Practitioner's Name: |
| 5. Relationship to Employee: □ Spouse □ Child □ Parent | 6. Practitioner's Area of Practice: |
| 7 Practitioner's Phone Number: | 8. Practitioner's Address: |
| Name of Nurse: | |
| | |
| PART II: TO BE COMPLETED BY MEDICAL PRACTITIONER | |
| 1. Nature of Health Condition: | |
| 2. Date Condition Commenced: | |
| 3. Probable Duration: | |
| Regimen prescribed or any other pertinent information regarding the patient: (Please be specific, attach clinical Notes if you prefer) | |
| 5. Please check "yes" or "no" as appropriate: Yes No Is in-patient hospitalization of the patient required: Image: Does the patient require assistance for basic medical or personal needs, safety and transportation: Image: Teatment: Image: Second Second | |
| 7. Signature of Practitioner: | Date: |
| HR Form 9.2 (Reproducible) Revised 08/05 | Enclosure to PIM #9 |
| Please return this form to: East Carolin Benefits Offi 210 E. 1 st Str Greenville, N | reet |

Our fax number is (252) 328-9918. This document will be treated confidentially. If you have questions please call (252) 328-9887