

Kean University

Leave of Absence Questionnaire

Employee Name: _____

Title: _____ Dept: _____

You have requested a medical leave of absence pursuant to the Family Medical Leave Act, the New Jersey Family Leave Act, and/or your collective bargaining agreement leave entitlements. In order to review your request, please provide medical certification from your physician that addresses the following questions. The doctor may either use this form or may provide a detailed letter.

*NOTE TO PHYSICIAN: The Genetic Information Nondiscrimination Act of 2008 (GINA) prohibits employers and other entities covered by GINA Title II from requesting or requiring genetic information of an individual or family member of the individual, except as specifically allowed by this law. **To comply with this law, we are asking that you not provide any genetic information when responding to this request for medical information.** "Genetic information" as defined by GINA, includes an individual's family medical history, the results of an individual's or family member's genetic tests, the fact that an individual or an individual's family member sought or received genetic services, and genetic information of a fetus carried by an individual or an individual's family member or an embryo lawfully held by an individual or family member receiving assistive reproductive services.*

1. Why is this employee unable to perform his/her job duties?

(Please include a statement or description of appropriate medical facts regarding the health condition for which the leave is requested. Such medical facts may include information on symptoms, diagnosis, hospitalization, doctor visits, whether medication has been prescribed, any referrals for evaluation or treatment (physical therapy, for example) or any other regimen of continuing treatment.)

2. First date employee was unable to work due to current medical condition necessitating a leave of absence: _____

3. Anticipated Recovery Date: _____

If date is not available, please indicate

- Return to work date is undetermined.
- Employee is permanently unable to return to work.

4. Is this condition temporary or permanent? Temporary. Permanent.

5. If this condition is temporary, what accommodations could the University consider that would allow this employee to return to work?

6. What is the expected duration of the accommodation/limitation?

7. Will the employee require leave of absence on an intermittent or reduced schedule basis?
Yes (specify if intermittent care or reduced schedule care is required) No

a. If yes, what is the expected duration of the intermittent or reduced schedule leave? _____

b. If yes, what is the estimate of hours the employee needs care on an intermittent or reduced schedule basis? Specify hours per day or week. _____

c. If yes, please explain the intermittent or reduced schedule care needed by the employee, and why such care is medically necessary. _____

Physician's Signature

Date

Physician's Printed Name/Specialty and Address

This form may be returned to you (the employee) by your doctor or submitted directly to the following address, at your written request:

Lorice Thompson-Greer, Managing Admin Asst-Benefits, Office of Human Resources, 1000 Morris Avenue, Union, NJ 07080 Fax: 908-737-3319