Kean University

Leave of Absence Questionnaire
Care of Family

Employee Name: _____

Title: _____ Dept: _____

Patient Name: _____ Relationship to Employee: _____

You have requested a medical leave of absence due to the serious health condition of your family member 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 family member's 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 entitles 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. Does the employee require a leave of absence to care for a family member with a serious health condition?
   □Yes (specify the relationship: _____) □ No

2. Explain the care needed by the employee's family member, and why such care is medically necessary.

   (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.)

   _____
   _____
   _____
   _____
   _____
   _____

3. What is the expected duration of the leave of absence: _____

4. Will the employee require leave of absence on an intermittent or reduced schedule basis to care for the family member?
   □Yes (specify if intermittent care or reduced schedule care is required) o 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 required for 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's family member, 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 the 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 07083 Fax: 908-737-3319