THE UNIVERSITY OF CHICAGO | Human Resources

Effective: 11/2018

LEAVE REQUEST FORM (Use for STD, Parental Leave, and MLOA)
HEALTHCARE PROVIDER'S STATEMENT

1) Have the "Healthcare Provider's Statement" completed and submitted directly to HR Leave Administration via email at leaveadministration@uchicago.edu or fax to 773-702-6098.
2) Healthcare Providers: Please note "unknown and undetermined" are not acceptable as answers. Specific dates must be provided where indicated.

IF REQUESTING SHORT-TERM DISABILITY OR PARENTAL LEAVE CONCURRENT WITH FMLA YOUR HEALTH CARE PROVIDER ONLY NEEDS TO COMPLETE THE APPLICABLE FMLA HEALTHCARE PROVIDER STATEMENT

Healthcare Provider's Statement

Patient's Name:

Diagnosis and current condition(s):

ICD-10 Diagnostic Code(s):

Date condition commenced:

Probable duration of condition:

Is the employee unable to perform any of his/her job functions due to the condition? ☐ Yes ☐ No

As of what date do you consider the employee disabled from performing any job functions?

Is the medical condition pregnancy? ☐ Yes ☐ No If so, expected delivery date: Expected delivery type: ☐ Vaginal ☐ C-section

Describe other relevant medical facts, if any, related to the condition for which the employee seeks leave:

Date employee may return to restricted duty: For what period (# of days):

State restrictions:

Date employee may return to regular duty: ☐ Estimate ☐ Actual

Healthcare Provider's Information

Healthcare provider's name: Type of practice/Medical specialty:

Provider's business address:

Telephone: Fax:

Signature: