UC Davis provides graduate students Family & Medical Leave Accommodation for any of the following reasons: the student's own serious health condition, the birth of a child or to care for a newborn, newly adopted child, or a newborn in foster care, the care of a family member with a serious health condition, bereavement, jury duty and military service. Any graduate student in good standing and supported by university academic employment or fellowship may be eligible. Talk to your supervisor or advisor about taking a Family and Medical Leave Accommodation. Leaves taken under this policy are paid or unpaid depending upon the nature and duration of the situation. However, depending on the reason for your leave, you may be able to use accrued vacation leave for all or a portion of the leave. A family and medical leave accommodation consists of several types of leave and, in certain circumstances, leaves may overlap or run concurrently. Leave accommodation will not extend beyond the end date of the appointment/award(s).

INSTRUCTIONS:

Graduate Student:

Complete the Leave Accommodation Request indicating your current status, type of support, reason for leave and requested begin and anticipated return dates. Indicate estimated period of paid, unpaid and vacation (if applicable) you wish to use.

Discuss your plan for leave with your supervisor or departmental staff. Continue to communicate with your supervisor or department staff during your leave to make adjustments to this request as needed.

Sign and date your request. Provide completed Health Care Certification with 15 days.

Submit form to: Home department (TA, AI, Reader, Tutor or GSR).
Graduate Studies, 250 Mrak (Fellowship)

Department:

Supervisor must review the plan with the student, review the request for approval, obtain chair/manager acknowledgement of the planned leave.

Payroll Processor:

Leaves less than 7 days in duration do not require data entry into PPS. Retain request in employee file. Leaves of greater than 7 days must be entered into PPS using the LVWP/LVNP bundle.

Use action code of 07 - Leave with Pay, 08 - Leave without Pay Enter Begin Date and Anticipated Return
FAMILY AND MEDICAL LEAVE ACCOMMODATION INSTRUCTIONS

Date
Enter Type: 04: Pregnancy disability  
05: Extended illness 
11: Military 
15: Family and medical leave without pay 
16: Family and medical leave with pay

Note: If leave is a combination of paid and unpaid, do not process more than one leave transaction for an employee on the same day. Ensure PPS is updated to return the employee to pay status at the end of any unpaid leave. No leave shall extend beyond the appointment end date.

Forward approved Leave Accommodation Request and Health Care Certification to Tracey Pereida, tgperida@ucdavis.edu, Graduate Studies.
FAMILY AND MEDICAL LEAVE ACcomMODATION REQUEST

Student Name: [ ]
Employee ID: [ ]
Student ID: [ ]
E-Mail: [ ]
Phone: [ ]
Dept/Program: [ ]
Supvr/Adviser: [ ]
Staff Contact: [ ]
Staff Phone: [ ]
Staff E-Mail: [ ]

ELIGIBILITY & SUPPORT

☐ I am currently registered in ____ units at UC Davis (summer registration not required)

☐ I hold an academic appointment as:
   ☐ Academic Student Employee (ASE - TA/Al/Reader/Tutor)
   ☐ Graduate Student Researcher (GSR)
   ☐ UC Davis Staff

☐ I have a Scholarship/Fellowship awarded by ____________________________.

TERM

Fall / Winter / Spring / Summer

UC Davis Staff

Please check reason for leave accommodation:

☐ Personal illness/disability, birth, adoption or care of family; family emergency. 2 day-qtr or 3 day-sem = Short-term Medical and Family Related Leave.

☐ Serious health condition, childcare-not childbearing. (medical certification may be required) (Type = 05, 15 or 16)

☐ 4 weeks max. paid = Long-term Medical and Family-Related Leave. (Type = 16)

☐ 2 weeks unpaid = Additional Unpaid Baby Bonding/Serious Illness Leave (VAC may be used) (Type = 16)

☐ Pregnancy Disability/Childbearing.

☐ 6 weeks max. paid = Long term Medical and Family-Related Leave (Pregnancy/Childbearing) (medical certification may be required) (Type = 04)

☐ 4 months max. unpaid = Pregnancy Disability Leave (VAC may be used) (medical certification may be required) (Type = 04)

☐ Bereavement - 3 scheduled work days

☐ Jury Duty - duration of summons

☐ Military Service - unpaid (Type = 11)

Requested Start Date: [ ] Anticipated Return Date: [ ]

I wish to use leave as estimated below:

<table>
<thead>
<tr>
<th>Type</th>
<th>Days/Weeks</th>
<th>From</th>
<th>Through</th>
</tr>
</thead>
<tbody>
<tr>
<td>Leave with pay</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Unpaid Leave</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Vacation</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Student Signature & Date: [ ]

☐ APPROVED BY: ☐ Provisionally Approved (pending Health Certification)

Supervisor/Advisor Signature: [ ]
Chair/Mgr Signature: [ ]
Name & Phone: [ ]
FAMILY AND MEDICAL LEAVE HEALTH CARE CERTIFICATION

PURPOSE of FORM:
The below-named student has requested a family and leave accommodation under university policy. This medical certification form will provide the University with information needed to determine if the student's requested leave is for a qualifying reason.

INSTRUCTIONS to STUDENT:
Please complete and sign Section II before giving this form to your health care provider. You are required to submit a timely, complete, and sufficient medical certification to support your request for accommodation. Providing this completed form is required to obtain the benefit of family and medical leave accommodation. Failure to provide a complete and sufficient medical certification to the University may result in a delay or denial of your leave request.

This form should be completed and returned within 15 calendar days. If you cannot return the completed form within the stated deadline, please contact with the reasons for the delay and the date when the certification will be provided.

You may return the form in person, by mail, or by fax. The fax number is .

You should include a fax cover sheet marked “CONFIDENTIAL” and address your fax to: “ATTENTION: .”

SECTION I – To be completed by THE UNIVERSITY

<table>
<thead>
<tr>
<th>STUDENT’S NAME</th>
<th>STUDENT ID# / EMPLOYEE ID#</th>
</tr>
</thead>
<tbody>
<tr>
<td>NAME OF UNIVERSITY REPRESENTATIVE</td>
<td>UNIVERSITY REPRESENTATIVE MAILING ADDRESS</td>
</tr>
<tr>
<td>TELEPHONE</td>
<td>FAX</td>
</tr>
</tbody>
</table>

SECTION II - To be completed by THE STUDENT

I am seeking certification for:

- [ ] my own serious health condition
- [ ] Pregnancy Disability/Childbearing
- [ ] care of a family member who has serious a health condition

Name of family member for whom you will provide care:

If family member is your child, date of birth: ____________________________

Relationship of family member to you: ____________________________

(1) Describe care you will provide to your family member and estimate the duration of leave needed to provide care.

SIGNATURE

STUDENT’S SIGNATURE ____________________________ DATE ____________________________
SECTION III – To be completed by HEALTH CARE PROVIDER

INSTRUCTIONS to the HEALTH CARE PROVIDER

The student named above has requested a family and leave accommodation under university policy. This medical certification form will provide the University with information needed to determine if the student's requested leave is for a qualifying purpose.

NOTE: DO NOT DISCLOSE ANY UNDERLYING DIAGNOSES WITHOUT THE STUDENT'S CONSENT.

PROVIDER'S NAME

BUSINESS ADDRESS

TELEPHONE

FAX

PART A: MEDICAL FACTS

1. Approximate date the student became or will become disabled by pregnancy, childbirth or related medical condition:

Probable duration of the period(s) of disability: From To

2. Serious Health Condition* for STUDENT or family member commenced:

Probable duration of the period(s) of disability: From To

* Serious health condition: an illness, injury, impairment or physical/mental condition that involves inpatient care and/or continuing treatment by a health care provider for a condition that causes more than 3 full consecutive calendar days of incapacity.

SIGNATURE

Signature of HEALTH CARE PROVIDER

Date