THE OHIO STATE UNIVERSITY

Certification of Qualifying Exigency for Military Family Leave

(Family and Medical Leave)

Employer Name

Employer Contact Information

SECTION 1: FOR COMPLETION BY THE EMPLOYEE

Instructions to the Employee: Please complete Section I fully and completely. The Family and Medical Leave Act (FMLA) permits an employer to require that you submit a timely, complete and sufficient certification to support a request for FML due to a qualifying exigency. Several questions in this section seek a response as to the frequency or duration of the qualifying exigency. Be as specific as you can; terms such as "unknown" or "indeterminate" may not be sufficient to determine FML coverage. Your response is required to obtain a benefit. 29 C.F.R. § 825.310. While you are not required to provide this information, failure to do so may result in a denial of your request for FML. Your employer must give you at least 15 calendar days to return this form to your employer.

Employee's Full Name: First M.I. Last OSU Employee ID# (required)

Name of covered military member on active duty or call to active duty status in support of a contingency operation:

First M.I. Last

Relationship of covered military member to you: _____

Period of covered military member's active duty: _____

A complete and sufficient certification to support a request for FML due to a qualifying exigency includes written documentation confirming a covered military member's active duty or call to active duty status in support of a contingency operation. Please check one of the following:

- ☐ A copy of the covered military member's active duty orders is attached.
- ☐ Other documentation from the military certifying that the covered military member is on active duty (or has been notified of an impending call to active duty) in support of a contingency operation is attached.
- ☐ I have previously provided my employer with sufficient written documentation confirming the covered military member's active duty or call to active duty status in support of a contingency operation.

The Genetic Information Nondiscrimination Act of 2008 (GINA) prohibits us from requesting/requiring genetic information of an individual or family member of the individual, except as specifically allowed by GINA. We ask that you not provide any genetic information when responding to this request for medical information. "Genetic information" includes an individual's family medical history, results of genetic tests, the fact that an individual/family member sought or received genetic services and genetic information of a fetus carried by an individual/family member/embryo lawfully held by an individual/family member receiving assistive reproductive services.

Part A: Qualifying Reason for Leave

1. Describe the reason you are requesting FML due to a qualifying exigency (include the specific reason you are requesting leave):

2. A complete and sufficient certification to support a request for FML due to a qualifying exigency includes any available written documentation that supports the need for leave; such documentation may include a copy of a meeting announcement for informational briefings sponsored by the military, a document confirming an appointment with a counselor or school official or a copy of a bill for services for the handling of legal or financial affairs. Available written documentation supporting this request for leave is attached.

☐ No ☐ Yes ☐ None Available

Employee's Full Name: First M.I. Last OSU Employee ID# (required)

Part B: Amount of Leave Needed

1. Approximate date exigency commenced: _____

Probable duration of exigency: _____

2. Will you need to be absent from work for a single continuous period of time due to the qualifying exigency? ☐ No ☐ Yes

If so, estimate the beginning and ending dates for the period of absence:

_____

3. Will you need to be absent from work periodically to address this qualifying exigency? ☐ No ☐ Yes

Estimate schedule of leave, including the dates of any scheduled meetings or appointments:

Estimate the frequency and duration of each appointment, meeting or leave event, including any travel time (i.e., 1 deployment-related meeting every month, lasting 4 hours):

Frequency: _____ times per _____ week(s) _____ month(s)

Duration: _____ hours _____ day(s) per event

Part C: Third Party Contact Information

If leave is requested to meet with a third party (such as to arrange for child care; attend counseling; attend meetings with school or child care providers; make financial or legal arrangements; act as the covered military member's representative before a federal, state or local agency for purposes of obtaining, arranging or appealing military service benefits; or attend any event sponsored by the military or military service organizations), a complete and sufficient certification includes the name, address and appropriate contact information of the individual or entity with whom you are meeting (i.e., either the telephone/fax number or email address of the individual or entity). This information may be used by your employer to verify that the information contained on this form is accurate.

Name of Individual: First M.I. Last Title

Organization

Address: Street City State Zip

Email Address

Describe nature of meeting: _____

Part D: Certification

I certify that the information I provided above is true and correct.

Signature of Health Employee Date

Direct questions and return form and any required documentation to your department human resources professional. Keep a copy of this form for your personal records.