Human Resources

RECOVERY LEAVE REQUEST FORM

INFORMATION ABOUT REQUESTING EMPLOYEE

Submit the completed form to Human Resources, Leaves Administration at leaves@arizona.edu.

The employee's personal or department representative may complete the form if the employee is incapacitated.

Name: _____ Empl ID: _____

Last, First MI

Personal Phone: _____ Personal Email: _____

EMPLOYEE ACKNOWLEDGEMENT

I request that I be allowed to take Recovery Leave. I understand that I must meet the following criteria to be eligible for recovery leave. Please read through each statement and add a checkmark in the box to indicate your agreement/understanding.

☐ 1. I or my spouse/partner suffered a pregnancy loss. Gestational age _____ weeks

☐ 2. I am a benefits-eligible employee and will have been employed for at least 12 continuous months before the commencement of the Recovery Leave.

☐ 3. I have not exceeded 12 weeks of paid parental leave in the last 12 months.

☐ 4. I have attached medical certification or medical records documenting my or my spouse/partner's pregnancy loss from the healthcare provider. (If you do not have documentation, contact Human Resources.)

☐ 5. If I do not return to work for at least 30 days after my approved leave, I agree to reimburse the University of Arizona for the salary and benefits I received during that period. I understand that my available sick and vacation leave accruals and compensatory time will first be applied toward this reimbursement.

LEAVE INFORMATION

I am requesting a leave of absence:

Beginning _____ Ending _____ Unpaid leave begins _____

_____ _____

Employee Signature Date

The employee is allowed 2 weeks if before 20 weeks gestational age and 12 weeks if at or after 20 weeks gestational age.

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INSTRUCTIONS TO THE HEALTH CARE PROVIDER:

A University of Arizona employee has requested paid leave to recover emotionally and physically from their own or their spouse/partner's loss of a pregnancy. Please certify the following information for the patient named below:

INFORMATION ABOUT REQUESTING EMPLOYEE

Name: _____ Empl ID: _____

Last, First MI

Patient Name (if different): _____

CERTIFICATION (initial all boxes below)

I certify that the patient named above experienced:

☐ Miscarriage (prior to 20 weeks gestational age)

☐ Miscarriage (at or after 20 weeks gestational age)

Date of event: _____

SIGNATURE

_____ _____

Provider Signature Date

_____ _____

Provider Name (printed) Phone

_____

Provider Address