# REQUEST FOR SICK LEAVE FOR VETERAN WITH SERVICE RELATED DISABILITY

Notice of Statutory Provisions: M.S. 43A.184

Pursuant to M.S. 43A.184, a state employee who is a veteran with a service related disability may apply to the employee's appointing authority for additional sick leave to receive treatment for the disability. The employee must qualify as a veteran under M.S. 197.447, and have a sick leave balance that is insufficient to receive treatment for the disability. The appointing authority may authorize up to an additional 40 hours of sick leave for the employee in the current fiscal year. The appointing authority may approve sick leave for an employee under these provisions one time in each fiscal year. Should the absence be FMLA qualifying, the 40 additional hours will be applied to the FMLA time limits.

This form must be submitted to the agency Human Resource Office.

SECTION I (to be completed by the Employee)

Employee Name: _____ Employee I.D. Number: _____

Agency: _____ Employee's Supervisor: _____

Number of Sick Leave Hours Being Requested: _____

Current Sick Leave Balance: _____

SECTION II – Certification of Service Related Disability

A copy of a Department of Veterans Affairs disability rating letter (or military service disability rating letter) verifying the employee's service related disability must be provided.

SECTION III – Certification of Treatment

The attached Certification of Treatment form must be completed and submitted to the Human Resources Office.

SECTION IV (to be completed by the Agency)

Request for additional sick leave: Is approved ☐ Is **not** approved ☐

Agency HR Rep Signature: _____ Date: _____

***If approved, follow these instructions to process the addition of sick leave hours to the employee's sick leave bank:***

*In Mass Time Entry, Current Period Adjustment or Prior Period Adjustment, enter earn code *SL and the number of hours to be added to the employee's sick leave balance.*

# CERTIFICATION OF TREATMENT FORM

*The Certification of Treatment form must accompany all requests for additional sick leave pursuant to M.S. 43A.184, Sick Leave for Veterans with Service-Related Disabilities*.

SECTION I (*to be completed by the Employer)*

Employee name:_____ Employee ID#_____

Employee's job title: _____ Regular Work Schedule:_____

Agency: _____

Employee's essential job functions OR position description is attached ☐

SECTION II *(to be completed by the Employee)*

**GENETIC INFORMATION NONDISCRIMINATION ACT OF 2008 DISCLOSURE**

This authorization does not cover, and the information to be disclosed must not contain, genetic information. "Genetic information" 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 reproductive services.

I, the undersigned individual, have requested additional sick leave pursuant to M.S. 43A.184, Sick Leave for Veterans with Service-Related Disabilities. To facilitate that request, I hereby authorize the Health Care Provider listed below to release information about my health condition and treatment thereof as it relates to my service-related disability. The specific health information that I am authorizing to be released is limited to the information requested in the below Certification of Treatment Form, and is limited to only information relating to my service-related disability.

The purpose for disclosure is to determine whether I qualify for additional sick leave pursuant to M.S. 43A.184, Sick Leave for Veterans with Service-Related Disabilities.

The information is to be released to Human Resources at the Agency listed in Section I above.

I understand that signing this form is voluntary. The Health Care Provider may not condition treatment, payment, enrollment or eligibility for health benefits on whether I sign this authorization.

This authorization is valid for one year from the date indicated below or upon receipt by the Health Care Provider of my signed, written notice to revoke my consent.

The information that is used or disclosed pursuant to this authorization may be re-disclosed by the receiving entity as allowed under state or federal law.

Employee Signature: _____ Date:_____

SECTION III *(to be completed by the Employee's Health Care Provider)*

**HEALTH CARE PROVIDER INSTRUCTIONS**

The employee listed above has requested additional sick leave pursuant to M.S. 43A.184, Sick Leave for Veterans with Service-Related Disabilities. Answer all applicable parts below as it pertains to the employee's service-related disability. Your answer should be your best estimate based upon your medical knowledge, experience, and examination of the patient. Be as specific as you can. The information to be disclosed must not contain, genetic information. "Genetic information" 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 reproductive services. Please be sure to sign the form.

1. Health Care Provider's Name and Business Address:_____

   _____

   Type of Practice/Medical Specialty:_____

   Telephone: (___) _____ Fax: (_____)_____ Email: _____

2. Is the patient being treated for a military service related disability? Yes ☐ No ☐

   Approximate date condition commenced:_____

   Probable duration of the condition and/or need for care:_____

   Dates or time period you have treated the patient for condition:_____

3. Use the information provided by the employer in Section I to answer this question. If the list of the employee's essential functions or a job description is not included, answer these questions based upon the employee's own description of his/her job functions.

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

   If so, identify the job functions the employee is unable to perform:

   For what period of time will the employee be unable to perform the job functions (either totally or partially)?

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

Health Care Provider Signature:_____ Date: _____