**Medical Care Leave Request Form**

**Step 1: Employee Action**. Complete the information and send it to your Line Manager (via email).

|  |  |
| --- | --- |
| Employee Name: |  |
| Staff Number: |  |
| Proposed Start Date: |  |
| Proposed End Date: |  |
| Duration of Leave (days)\*: |  |
| **Details of Specified Individual** |
| Name of the Specified Individuals: |  |
| Address of the specified individual: |  |
| Relationship to the above individual: |  |
| **Statement of Facts that the Reasoning to Take Medical Care Leave** |
| Enter the reasoning: |

\*Please note that the maximum duration for Medical Care Leave is 5 days in any period of 12 consecutive months. By completing this form, you (the employee) are confirming the following:

1. You understand that this is unpaid leave.
2. You agree to the necessary salary adjustment required for this period of leave in the next available payroll.
3. You have not availed of the 5 days leave in the preceding 12 months.

**Evidence**

The employer reserves the right to request relevant evidence relating to the need of the person for the significant care or support concerned. Such relevant evidence may include:

* A medical certificate stating that the person named in the certificate is, or where the leave has already been taken, was in need of significant care or support for a serious medical reason and signed by a registered medical practitioner within the meaning of section 2 of the Medical Practitioners Act 2007, or;
* If the employee does not have a medical certificate such evidence as the employer concerned may reasonably require in order to show that the person concerned is or was in need of significant care or support for a serious medical reason.

**Data Protection**

The information contained in this document will be processed in accordance with our obligations under data protection law.

As this document may contain special categories of personal data, it will be stored in a separate file. This is done to ensure the highest level of confidentiality and to ensure that only authorised personnel have access to it.

**Declaration**

**I declare that the information given by me above is true, accurate and complete.**

**Signature of Employee: Date:**

**Step 2: Manager Action.** Following the Manager and Employee discussion, the Manager completes and emails to the employee.

|  | **Yes** | **No** |
| --- | --- | --- |
| Request Approved? |  |  |
| Has the employee provided the necessary information and/or supporting documents? |  |  |
| Has the hea of School/Unit/Area provided approval for the individua to take Medical Care Leave? |  |  |

**Signature of Head of School/Area:**

**Date:**

**Please print name:**

**Step 3:** The manager and employee should retain a copy of this form.

Once the above form is completed, please submit the Form and Supporting documents to HR@tcd.ie.

***Note for Heads/Manager:*** *This form may contain medical information. Adequate security measures and safeguards must therefore be implemented to ensure that the security of the data is protected.*

**Step 4:** HR will acknowledge receipt of the leave, make a note of the absence and action the necessary salary adjustment.