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| **UNIVERSITY COLLEGE DUBLIN**  **Notification of Intention to take Medical Care Leave** |

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| 1. ***An employee is entitled to leave without pay for the purpose of providing personal care or support to persons specified in the policy and the person specified needs significant care or support for a serious medical reason.*** 2. ***The persons specified in the policy; a person whom the employee is the relevant parent or acting on loco parentis, spouse, civil partner, cohabitant, parent, grandparent, brother or sister, or a person who lives in the same house and is in need of significant care or support for a serious medical reason.*** 3. ***Medical Care Leave cannot exceed five working days in any twelve consecutive months.*** 4. ***An employee may be required to produce relevant evidence such as a medical certification or evidence as may be reasonably required in order to show that the person concerned is or was in need of significant care or support for a serious medical reason.*** |

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| **To be completed by the employee applying for Medical Care Leave** | |
| Name: | Personnel No: P |
| School/ Unit: | Approver: |
| Name of person in need of care or support from employee during Medical Care Leave: | |
| Relationship of employee to person in need of care: | |
| Nature of personal care or support required to be given by the employee to the person concerned: | |
| Date(s) of Medical Care Leave: | Number of days to be taken: |

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| *I confirm that I have taken Medical Care Leave on the above-mentioned date(s) for the purpose of providing personal care or support to the person specified above and the person specified needed significant care or support for a serious medical reason.*  **DECLARATION**  *I declare that the information given above by me is true, accurate and complete in all respects and I both understand and accept that if that is not the case, whether knowingly on my part or otherwise, then, following due investigation by my employer, I may be denied Medical Care Leave and/or liable to appropriate disciplinary action.* | | | |
| **Signature of Employee:** |  | **Date:** |  |

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| *I have checked that the start and end dates specified comply with requirements and that the overall period indicated does not exceed that which is allowed under this leave. I have examined the documentation and information provided and confirm that the leave approved complies with the relevant HR policy.* | | | |
| **Signature of Manager:** |  | **Date:** |  |