THE UNIVERSITY OF ARIZONA
Human Resources

REQUEST FOR MISCARRIAGE/STILLBIRTH RECOVERY LEAVE

Employee Name:

Department Name:

Employee Email: **Employee Phone:**

Allowance: 2 weeks if prior to 20 weeks gestational age; 12 weeks if at or after 20 weeks.

I certify that I meet the following requirements for leave:

1. I or my spouse/partner suffered a pregnancy loss at weeks gestational age.
2. I am a benefits-eligible employee and will have been employed for at least 12 continuous months prior to 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 my healthcare provider. (If you do not have documentation, contact Human Resources.)

Requested Leave Dates: From (first day of leave) To (last day of leave)

Flex Leave:

☐ I plan to take weeks of continuous leave.

- Paid Leave dates:
- Unpaid Leave dates:

☐ I plan to take weeks of partial leave. My work schedule will be as follows:

In the event 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 my period of leave. I understand that my available sick and vacation leave accruals and compensatory time will first be applied towards this reimbursement.

Employee Signature: _____ Date:

Supervisor Approval: _____ Date:

Supervisor Name (please print):

Submission: Complete the patient and employee information on the following Certification form and obtain an electronic or physical signature confirming pregnancy loss. The healthcare provider may use an alternate form or signed letter in lieu of this form. Alternatively, you may submit a medical record and redact any information unrelated to loss of pregnancy.

Retain a copy of the signed form and medical provider certification, and submit copies to the Human Resources Leave Advising team at hrsolutions@arizona.edu or via our secure document upload portal at https://hr.arizona.edu/submit-documents.

THE UNIVERSITY OF ARIZONA
Human Resources

REQUEST FOR MISCARRIAGE/STILLBIRTH RECOVERY LEAVE

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:

Patient Name:

University Employee Name, if Different: **Employee ID:**

I certify that the patient named above experienced:

◯ Miscarriage (prior to 20 weeks gestational age)

◯ Stillbirth (after 20 weeks gestational age)

Date of event:

Signed by: Date: