Sworn Statement

Authorization Employee Section:

I certify that I have provided accurate and complete information as required with the Application for Medical Leave of Absence and that any misrepresentation may be cause for denial of the leave of absence. _____ Initial

I do hereby authorize any physician, dentist, health care provider, hospital or other medical facility to furnish information that relates to my employment and medical leave of absence to Human Resource Services at Hanover Township, or its authorized evaluating physician to complete my application for a medical leave of absence. _____Initial

If the request is for a medical leave of absence pursuant to the FMLA/FIL I understand I must provide the required medical certification to Human Resource Services as soon a practical but not to extend beyond 15 calendar days after the completion of the medical leave of absence. For foreseeable medical leaves the request for leave must be completed 30 calendar days in advance. Failure to comply may result in denial of my application for a medical leave of absence. _____Initial

Please complete for **VESSA leaves only**.

I understand that I must provide the required supporting documentation for a VESSA leave of absence within 48 hours when practical or as soon as possible under certain circumstances. _____Initial

Upon request of the Township, I do hereby authorize any individual or representatives of an organization who has provided assistance to me and/or a household member, to furnish information that relate to employment and the VESSA leave of absence _____Initial.

I do hereby authorize Human Resources to release any medical records or personal information in their possession, related to employment and/or medical leave of absence to any Medical Provider/Consultant _____Initial

I authorize Human Resources to exchange information with any other Township entity deemed appropriate. _____Initial

_____ _____

Employee's Name (Please Print) Employee's Signature

_____

Date

==========

Family/Household Member's Section:

I do hereby authorize any physician, dentist, health care provider, hospital or other medical facility to furnish information that relates to my employment and medical leave of absence to Human Resources at Hanover Township or its authorized evaluating physician to complete my application for a medical leave of absence. _____Initial

If the request is for a medical leave of absence pursuant to the FMLA/FIL I understand I must provide the required medical certification to Human Resources as soon a practical but not to extend beyond 15 calendar days after the completion of the medical leave of absence... For foreseeable medical leaves the request for leave must be completed 30 calendar days in advance. Failure to comply may result in denial of the medical leave application for the qualifying employee. _____Initial

Please complete for **VESSA leaves only**

Upon request of NIU, I do hereby authorize any individual or representatives of an organization who has provided assistance to me to furnish information that relate to employment and the VESSA leave of absence _____Initial

I understand that I must provide the required supporting documentation for a VESSA medical leave of absence within 48 hours when practical or as soon as possible under certain circumstances. Initial

I do hereby authorize Human Resources to release any medical records or personal information in their possession, related to employment and/or my medical leave of absence to any Medical Provider/Consultant. _____Initial

I authorize Human Resources to exchange information with any other Northern Illinois University entity deemed appropriate. _____Initial

_____ _____

Family/Household Member's Name(Please Print) Family/Household Member's Signature

Date

Note: If family/household member is a minor, no signature is required

A photocopy of this authorization shall be considered as effective and valid as the original regardless of the date signed.