Parental Leave

**Health Care Provider Certification**

*The following graduate student at North Carolina State University has requested parental leave from her academic responsibilities as a graduate student. This form is used to provide confirmation from a medical service provider of the expected birth/adoption/foster care placement of the child.*

***Student Information:***

|  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Name: |  | | | | | | | ID Number: | | |  |
|  | | | | | | | | | | | |
| Degree: | |  | | Major/Program: | | |  | | | | |
|  | | | | | | | | | | | |
| Campus Box: | | |  | | Email Address: | | | |  | | |
|  | | | | | | | | | | | |
| Home Phone: | | |  | | | Work Phone: | | | |  | |
|  | | | | | | | | | | | |
| ***Expected Date of Birth or Commencement of Child Care:*** | | | | | | | |  | | | |
|  | | | | | | | | | | | |
| ***Authorization:*** I affirm that the information provided regarding my parental leave request is true and accurate to the best of my knowledge. I authorize the release of medical information for the specific and limited purpose of confirming the estimated due date in relation to the request for temporary release from academic duties. | | | | | | | | | | | |
| *signature/date* | | | | | | | | | | | |

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***Certification*** (to be completed by the Health Care Provider):

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Health Care Provider: | |  | | | |
|  | | | | | |
| Address: |  | | | Phone: |  |
|  | | | | | |
| Name of Health Care Certifier: | | |  | | |
| *I affirm that the information provided above is true and accurate to the best of my knowledge.* | | | | | |
| *signature/date* | | | | | |