Graduate Assistant Parental Leave Program Medical Certification

Provider Information:

Graduate Assistant's/Family Member's Healthcare Provider or Agency Information*****

Healthcare Provider's Name or Agencies Name and Representative**:**

Title: _____

Address: _____

Phone Number: _____

State the approximate start date:

Type of Leave (circle one): Birth, Adoption, or Foster Placement

Estimated date of birth/adoption/placement and requested leave dates:

Start Date: _____ End Date: _____

*****If this request is for Adoption or Placement, please attach the placement confirmation

Signature of
Healthcare Provider or Agency Representative: _____

Date: _____

Email: AbsenceManagement@unr.edu
Fax: (775) 784-1073

University of Nevada, Reno
Human Resources