



UNIVERSITY OF CENTRAL ARKANSAS

Certification of Adoption/Foster Care Placement

To be completed by the employee:

| | |
|------------------|----------------------------|
| Employee Name: | Employee ID#: |
| Department: | Length of Leave Requested: |
| Supervisor Name: | |
| Signature: | Date: |

To be completed by the placement professional or agency:

Please attach relevant documentation.

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|--|
| <p>This document confirms that _____ (Employee Name) is working with/has worked with _____ (agency or law firm name) regarding the adoption or placement in foster care of a son or daughter.</p> <p>The anticipated or actual date of placement is: _____</p> |
| <p>Agency Address and phone number: _____</p> <p>_____</p> <p>_____</p> <p>_____</p> |

Agency official's signature: _____ Date: _____