THE UNIVERSITY of TENNESSEE HEALTH SCIENCE CENTER

Request for Family & Medical Leave

Name:_____Request Date : _____

Employee ID:_____ ☐ Bi-Weekly ☐ Monthly

Employment Date:_____Hours Worked* in Prior 12 Months: _____

***Do Not Count Leave Hours**

Department_____Supervisor Name**_____

**will receive determination of this request

Office Phone: _(_____)_____ Home Phone: _(_)_____

Home Address:_____City_____State_____Zip_____

Name of Spouse if employed at UT:_____Spouse ID: _____

Serious Illness of: ☐ Employee ☐ Parent ☐ Spouse

☐ Child Age:_____ Incapacitated: ☐ Yes ☐ No

Is your condition due to an on-the-job injury? ☐ Yes ☐ No

CERTIFICATION BY A HEALTH CARE PROVIDER MUST BE PROVIDED.

Birth, Adoption or Foster Care Placement:

Name of Child: _____

Expected Date of Birth: _____

Date of Adoption: _____

CERTIFICATION BY A HEALTH CARE PROVIDER IS NOT NEEDED.

Leave Period Requested or Taken:	Begin. Date	End Date
Sick Leave:	_____	_____
Annual Leave:	_____	_____
Personal Leave Day:	_____	_____
Leave Without Pay***	_____	_____

*****Supervisors: Please submit a PIF for any leave of absence without pay after two weeks.**

Do you wish to retain up to 5 days or 40 hours (whichever is less) of sick leave?____Yes____No

If yes, number of hours_____

Please note that you cannot retain sick leave while on leave without pay or if receiving hours from the sick leave bank.

I understand that the University will pay the employer portions of the group medical insurance during my leave of absence without pay, if approved under the Family and Medical Leave Act of 1993, **provided I pay the employee portion** to the Campus Insurance Office, 910 Madison Avenue, Suite 753, Memphis, TN 38163. All other insurance plans must be fully paid by me. If I drop the plan(s), participation rules and legal requirements will govern reinstatement. I also understand that I will not accrue leave or receive retirement creditable service while on leave without pay except for approved worker's compensation.

_____ _____

Employee Signature* Date

If the employee is unavailable, a supervisor or departmental representative may complete this form.

For Personnel Use Only

☐ Approved ☐ Denied

_____ _____

Personnel Signature Date