# TENNESSEE STATE UNIVERSITY
## Request for Family and Medical Leave

Employee Information

Name: ________________________________________ Employee T#: _________________________

Employment Date: ________________________ Leave Period: _________________________________

Department: ____________________________Office Phone: _________________________

Home Phone: ____________________________________Purpose of Leave Request:

**Serious Illness of**: _____Employee _____Parent _____Spouse

_____Child Age: _____ (if under age 18 years of age or Incapacitated): _____Yes _____No

**Birth, Adoption, or Foster Care Placement**:

Name of Child: ______________________________________

*Date of Birth: ______________________________________

Date of Adoption/Placement: ____________________________

* Please provide a copy of adoption placement papers and/or birth certificate.

Designation of Leave Usage: **Begin Date _____________ End Date _______________**

Sick Leave ___________________ ___________________

Annual Leave ___________________ ___________________

Leave Without Pay ___________________ ___________________

** **Special Leave Requests**:

Intermittent Leave _____Yes _____No

Reduced Work Schedule _____Yes _____No

** **Certification of Health Care Provider form must be completed for approval of intermittent leave/reduced work schedule. You must maintain the schedule and submit it to Human Resources periodically and upon completion of the FMLA period.**

I understand the following:

(1) I may be required to furnish a **completed Certification of Health Care Provider form** in order for Family and Medical Leave to be approved.
(2) The institution will pay the employer portions of the group medical insurance (matching portion) during any approved unpaid FMLA leave, provided I pay the employee portion in accordance with the payroll deadline date. All other insurance plans that I wish to continue during the FMLA period must be fully paid by me.

(3) If I elect not to continue insurance coverage during the FMLA leave period, I must notify the insurance preparer in writing prior to the beginning of the leave. If plans are voluntarily cancelled prior to the leave, I must request that coverage be reinstated within thirty-one (31) days of my return to work. Premiums that would have been due during the FMLA leave for optional plans will be deducted from my paycheck.

(4) If I do not return to work, I will be responsible for reimbursing the institution for employer premiums paid in my behalf during an unpaid FMLA leave period.

I will not have to repay premiums if I do not return to work for the following reasons: (a) continuation, recurrence, or onset of a serious health condition of myself or an immediate family member; or (b) other circumstances beyond my control- not voluntary).

(5) If my period of leave continues beyond the twelve (12) workweeks provided in the Family and Medical Leave Act of 1993, I must notify the insurance preparer in writing if I wish to drop coverage for the remainder of the leave period. This notification must be received no later than the last day of the month in which my insurance is continued under the provisions of FMLA leave.

(6) I will not accrue leave while on Leave-without-pay.

Employee Signature: ________________________________________ Date: _______________________

Part II - Employer Review and Recommendation(s)

Supervisor/Department Head: _________________________________ Date: _______________________

Recommend Approval: ____Yes ____No Comments: ___________________________________

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Human Resources Officer: _________________________________ Date: _______________________

Approved: ______ Not Approved: ______

FMLA Eligibility Status: Worked previous year (12 months): ______Yes ______No
and worked at least 1250 hours: ______Yes ______No

HR Staff Initials / Date

______________/____________

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