Print Form

TENNESSEE BOARD OF REGENTS **Attachment A**

Request for Family and Medical Leave

PART I - Employee Information

Name: _____ Employee SSN: _____

Employment Date: _____ Leave Period: _____

Office Phone: _____ Home Phone: _____

Spouse SSN: _____ Agency/Dept. Code #: _____

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/technology center/Central Office 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/technology center/Central Office 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
_____ / _____