

TENNESSEE BOARD OF REGENTS
Request for Family and Medical Leave

PART I – Employee Information

Employee Name _____ Banner ID T _____

Employment Date _____ Leave Period _____

Office Phone _____ Home Phone _____

Name of Spouse if Employed by State _____

Purpose of Leave Request:

Serous Illness of:

_____ Employee _____ Parent _____ Spouse

_____ Child: Age _____ 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 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.

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/school/Central Office will pay the employer portions of the group medical insurance 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 coverages be reinstated within 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/school/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 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 or receive longevity payment while on leave without pay.

Employee Signature _____ Date _____

PART II – Employer Review and Recommendations

Supervisor/Department Head _____

Recommend Approval: Yes _____ No _____

Human Resources Officer _____ Date _____

Approved _____ Not Approved _____