THE UNIVERSITY of TENNESSEE UT
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 employee 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 in advance** to the Campus Insurance Office, 910 Madison Avenue, Suite 727, 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

Revised March 2017