

## The University of Tennessee Request for Family and Medical Leave

Name: \_\_\_\_\_ Responsible Account: \_\_\_\_\_  
 Employee ID: \_\_\_\_\_ Bi-Weekly  Monthly   
 Employment Date: \_\_\_\_\_ Request Date: \_\_\_\_\_  
 Hours Worked in Prior 12 Months: \_\_\_\_\_ Office Phone: \_\_\_\_\_  
Do Not Count Leave Hours  
 Home Address: \_\_\_\_\_  
 Name of Spouse if employed at UT: \_\_\_\_\_ Spouse ID: \_\_\_\_\_

Serious Illness of:       Employee                       Parent                       Spouse  
                                   Child      Age: \_\_\_\_\_      Incapacitated:  Yes       No  
 Is your disability 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	_____	_____
Worker's Compensation:	_____	_____

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.

\_\_\_\_\_  
Supervisor/Department Head

\_\_\_\_\_  
Date

\_\_\_\_\_  
Personnel Approval

\_\_\_\_\_  
Date

**Send through a PIF, if there is any leave of absence without pay.**