



The University of Tennessee Family and Medical Leave (FML) Request Form

To request Family and Medical Leave, complete this form. In addition, medical certification by a health care provider may be required by your supervisor/department head. If required, the certification must also be submitted to Human Resources, **105 Student Services Building Knoxville, TN 37996-0213 (fax: 865.974.6066)**. The Human Resources Office will forward copies of any approval letters to the employee, employee's supervisor/department head, and the Payroll Office.

Name: _____ UT ID Number: _____

Department: _____ Cost Center: _____

Employment Date: _____ Circle One: Biweekly Employee or Monthly Employee

Supervisor/Department Head: _____

Home Address: _____
(Street) (City) (State) (Zip Code)

Phone Numbers: Cell _____ Home _____ Work _____

FML Start Date: _____ FML End Date (If Known): _____

This request is for the serious health condition of (select one): If applicable, select one:

- | | |
|--|---|
| <input type="checkbox"/> Employee | <input type="checkbox"/> Birth (Maternity/Paternity) –
Date of Birth _____ |
| <input type="checkbox"/> Spouse – Name _____ | <input type="checkbox"/> Adoption –
Date of Adoption _____ |
| <input type="checkbox"/> Parent – Name _____ | <input type="checkbox"/> Foster Care Placement –
Date of Placement _____ |
| <input type="checkbox"/> Child – Name _____
Child's Date of Birth _____ | <input type="checkbox"/> Qualifying Exigency |
| <input type="checkbox"/> Covered Service Member – Name _____ | |

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 _____.

I understand the University will pay the employer portion of the group medical insurance premium for up to 12 weeks of any leave which qualifies under the Family and Medical Leave Act of 1993, provided I pay the employee portion in advance to the Treasurer's Office, P115 Andy Holt Tower, Knoxville, TN, 37996-0100. All other insurance plans must be fully paid by me. If I choose not to pay my medical and/or optional plan premiums, I understand my coverage will lapse during my leave without pay. I also understand I will not accrue leave or receive retirement creditable service while on leave without pay. I understand the time requested, paid or unpaid, will count against my 12-weeks of FML during this 12-month period.

(Employee Signature)

(Date)

Regular hours worked in prior 12 months: _____
(Minimum requirement = 1,250 Hours)

Is medical certification required? ___YES ___NO

(Supervisor/Department Head Signature)

(Date)

(Human Resources Signature of Approval)

(Date)