The University of Tennessee

FAMILY AND MEDICAL LEAVE (FML)

Name: ______________________________ Cost Center: ______________________

Employee Personnel No.: __________________ Biweekly: ________ Monthly: ________

Employment Date: ______________________ Supervisor/Dept. Head: ________________

Home Address ____
Street City State Zip

Phone Numbers - Home: ______________ Work: ______________ Cell: ____________

Serious Illness/Injury of: Employee________ Parent________ Spouse________

Child________ Age________ Incapacitated? _____Yes _____No

Certification by a health provider may be required by the department head. If required, the certification must be submitted to Human Resources, 600 Henley Street, Suite 230, Knoxville, TN 37996-4125.

( ) Birth ( ) Adoption ( ) Foster Care Placement

Name of Child: ________________________________ Date of Birth: ______________

Date of Foster Care Placement: ____________________ Date of Adoption: ____________

Beginning Date for FML: ________________ End Date for FML (if known):______________

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-week entitlement of this 12-month FML period.

______________________________________ ______________________

Employee Signature Date

TO BE COMPLETED BY EMPLOYEE'S DEPARTMENT:

Hours worked in prior 12 months: ______________ Is medical certification required? ___Y ___N
(Minimum required 1,250 hours)

______________________________________ ______________________

Supervisor/Department Head Date

______________________________________ ______________________

HR/Personnel Approval Date

Beginning date of current 12-month Family and Medical Leave Period: ______________________
The Human Resources Office will forward copies of approved forms to the employee, employee's supervisor/department head, and the University Payroll Office.