THE UNIVERSITY OF TENNESSEE
FAMILY AND MEDICAL LEAVE (FML)

Name:_____ Responsible Account:_____

Employee ID:_____ Biweekly: [ ] Monthly: [ ]

Employment Date:_____ Office Phone:_____

Hours Worked in Prior 12 Months:_____ Home Phone:_____

Home Address:_____

Name of Spouse if Employed at UT:_____

Spouse ID:_____

Serious Illness 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 with this form.

[ ] Birth [ ] Adoption [ ] Foster Care Placement

Name of Child:_____

Date of Birth:_____

Date of Adoption:_____

Leave Period Requested or Taken:	Begin Date:	End Date:
Sick Leave:		
Annual Leave:		
Personal Leave Day:		
Leave Without Pay:		
Workers' Compensation:		

I understand that 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 or the campus/unit insurance office. 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 that my coverage will lapse during my leave without pay. I also understand that 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 during my current 12 month FML period.

_____ _____
Employee Signature Date

Is medical certification required? [ ] Yes [ ] No

_____ _____ _____ _____
Supervisor/Department Head Date Personnel Approval Date

Beginning Date of Current 12 Month Family and Medical Leave Period:_____

The Personnel/Business Office will send copies of approved forms to the employee, employee's supervisor/department head, and the University-wide Payroll Office.

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