THE UNIVERSITY of TENNESSEE HEALTH SCIENCE CENTER

Request for Family& Medical Leave - Residents

Name: _____ Request Date : _____ *Do Not Count Leave Hours

Employee ID: _____ ☐ Bi-Weekly ☐ Monthly

Employment Date: _____ **Hours Worked* in Prior 12 Months:** _____

Program Phone: (_____)_____ Home/Cell 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 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:	_____	_____
Leave Without Pay**	_____	_____
Worker's Compensation:	_____	_____

****Supervisors: Please submit a PIF for any leave of absence without pay.**

I understand that the University will pay the employer 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 1031, 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.

_____ _____
Employee Signature Date

_____ _____
Program Coordinator or Director Signature Date

_____
Program Coordinator or Director Printed Name

For Personnel Use Only

☐ Approved ☐ Denied

_____
Personnel Signature

_____
Date

Revised January 2012