Austin Peay State University
Office of Human Resources

Family, Medical and Servicemember Leave Request

Section I: Employee Information

Employee Name: _____ Employee A#: _____

Employee Title: _____ Hire Date: _____

Employee E-Mail Address: _____ Employee Phone: Work _____ Cell _____

Employee Mailing Address: _____ City: _____ State: _____ Zip Code: _____

Supervisor Name: _____ Department: _____

Is your spouse a State of Tennessee employee: ☐ Yes ☐ No

If yes, provide spouse name and agency: _____ _____

Section II: Leave Request

In agreement with the Family, Medical and Servicemember Leave Policy (5:021), FMLA **may be** designated to an employee, if they meet two of the following criteria's:

1. A serious illness of employee, spouse, parent, or child under 18 years of age or for an ongoing medical event as it may relate to FMLA or for maternity, paternity, adoption, qualifying exigency or military caregiver leave.
2. Employed by Austin Peay State University for one (1) year and worked 1250 hours in the preceding year.

The purpose of this leave request is for (please check one):

☐ Serious illness of employee
☐ Serious illness of parent
☐ Serious illness of spouse
☐ Serious illness of child (Name and date of birth :_____)
Incapacitated ☐ Yes ☐ No

☐ Qualifying Exigency Leave
☐ Military Caregiver Leave
☐ Maternity/Paternity Leave (due date: _____)
☐ Adoption (due date: _____)
Provide copy of adoption document and/or certificate

Requested start date: _____ Anticipated end date: _____

Designation of Leave Usage

Sick Leave:	Begin date: _____	End date: _____
Annual Leave:	Begin date: _____	End date: _____
Leave Without Pay:	Begin date: _____	End date: _____

Leave Requests

Intermittent Leave: ☐ Yes ☐ No
Reduced Work Schedule: ☐ Yes* ☐ No (*If yes, please attach an expected schedule)

Section III: Employee Signature

I understand the following:

I am required to complete a **FMLA Leave Certification of Health Care Provider** form and submit the form to the Office of Human Resources Benefits before my leave commences. The form should be returned to the Office of Human Resources within 15 days. If I am not able to return the form within the allowed timeframe, I will contact the Office of Human Resources for assistance. The Certification of Health Care Provider form is held in a confidential medical file. It is not part of the HR personnel file.

If my leave is approved, my time away from work will be charged against my 12 week leave maximum under FMLA. Upon approval of this requested leave, I am required to utilize all paid time available to me prior to going into an unpaid leave status. The institution will pay the employer portions of the group medical insurance during any approved unpaid FMLA leave, provided I pay the employee portion in accordance with the payroll deadline date. All other insurance plans that I wish to continue during the FMLA period must be fully paid by me.

If I elect not to continue insurance coverage during the FMLA leave period, I must notify the insurance preparer in writing prior to the beginning of the leave. If plans are voluntarily canceled prior to the leave, I must request that coverage be reinstated within 31 days of my return to work. Premiums that would have been due during the FMLA leave for optional plans will be deducted from my paycheck.

If I do not return to work, I will be responsible for reimbursing the institution for employer premiums paid in my behalf during an unpaid FMLA leave period. I will not have to repay premiums if I do not return to work for the following reasons: (a) continuation, recurrence, or onset of a serious health condition of myself or an immediate family member or (b) other circumstances beyond my control (not voluntary). In the event that I go into an unpaid status while on leave, I understand that I must contact the Office of Human Resources to make arrangements to pay my portion of insurance premiums.

I have☐ have not☐ notified my department.

I certify to the best of my knowledge that all of the information on this form is correct.

Employee Signature:_____ Date: _____

Required Documents Enclosed: ☐ Yes ☐ No

Section IV: Employer Review

Supervisor/Department Leader: _____ Date: _____

Supervisor Acknowledgment: ☐ Yes ☐ No

Human Resources Representative:_____ Date: _____

Recommended Approval: ☐ Yes ☐ No