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

To request Family and Medical Leave, please complete this form. For serious health conditions, a medical certification completed by a health care provider is required in order for the request to be approved. Both completed documents must be submitted to Human Resources, **105 Student Services Building Knoxville, TN 37996-0213** (**fax: 865.974.6066, email: FamilyMedicalLeave@utk.edu**). 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 Personnel Number: _____

Department: _____ Cost Center: _____

Supervisor: _____ Supervisor Email: _____

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

Phone Numbers: Cell _____ Home _____ Work _____

FML Start Date (if known): _____

Type of FML requested: ☐ Intermittent ☐ Consecutive

This request is for the serious health condition of (select one):
(medical certification required)

- ☐ Employee
- ☐ Spouse – Name _____
- ☐ Parent – Name _____
- ☐ Child – Name _____
  Child's Date of Birth _____

If applicable, select one:
(medical certification not required)

- ☐ Child Birth (Maternity/Paternity) –
  Due Date _____
- ☐ Adoption –
  Date of Adoption _____
- ☐ Foster Care Placement –
  Date of Placement _____
- ☐ Qualifying Exigency (Armed Services)

Do you wish to retain up to 40 hours of sick leave for use outside of FML? ☐ No ☐ Yes, number of hours _____.

I understand the University will pay the employer portion of the group medical insurance premium for up to 12 weeks (4 months under the Tennessee Parental Leave Act if applicable) 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. While on FML, I understand if I run out of leave accruals and am placed in an unpaid leave status I will be responsible for paying my portion of my insurance premiums directly to payroll or my coverage will lapse. 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)**

Supervisor/Department Head ONLY

_____ _____
(Supervisor/Department Head Signature) **(Date)**

Human Resources ONLY

_____ Employment Date: _____
(Human Resources Signature)

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