

**AUSTIN PEAY STATE UNIVERSITY
Request for Family and Medical Leave**

PART I - EMPLOYEE INFORMATION

Name: _____ Employee SSN: _____

Employment Date: _____ Leave Period: _____

Office Phone: _____ Home Phone: _____

Name of Spouse if Employed by the State: _____

Spouse SSN: _____ Agency Code #: _____
 Purpose of Leave Request: _____
 Serious Illness of: _____
 (Spouse Agency Code-Leave blank if unknown)

Employee	Parent	Spouse	Child Age:	Incapacitated:	Yes	No
Birth, Adoption, or Foster Care Placement:						
Name of Child			Date of Birth			

*Date of Adoption/Placement

* Please provide a copy of adoption placement papers and/or certificate.

Designation of Leave Usage:

Sick Leave	Begin Date	End Date
Annual Leave	Begin Date	End Date
Leave Without Pay	Begin Date	End Date

**Special Leave Requests:

Intermittent Leave	Yes	No	Reduced Work Schedule	Yes	No
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**Certification of Health Care Provider form must be completed for approval. Contact the Office of Human Resources for the required form.

I understand the following:

1. I may be required to furnish a completed Certification of Health Care Providers from in order for Family and Medical Leave to be approved.
2. 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.
3. 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.
4. 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).
5. If my period of leave continues beyond the twelve (12) workweeks provided in the Family and Medical Leave Act of 1993, I must notify the insurance preparer in writing if I wish to drop coverage for the remainder of the leave period. This notification must be received no later than the last day of the month in which my insurance is continued under the provisions of FMLA leave.
6. I will not accrue leave while on leave without pay.

Employee Signature: _____ Date: _____

PART II - Employer Review and Recommendations

Supervisor/Department Head: _____ Date: _____

Recommend Approval: Yes _____ No _____

Director for Human Resources: _____ Date: _____

Approved: _____ Not Approved: _____