

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

**PART I - EMPLOYEE INFORMATION**

Name: \_\_\_\_\_ A#: \_\_\_\_\_  
Employment Date: \_\_\_\_\_ Leave Period: \_\_\_\_\_  
Office Phone: \_\_\_\_\_ Home Phone: \_\_\_\_\_  
Street Address: \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ ZIP Code: \_\_\_\_\_  
Name of Spouse if Employed by the State: \_\_\_\_\_

**Purpose of Leave Request**

Serious Illness of:	Employee:	Parent:	Spouse:	Child:
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

\*\*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 form 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 \_\_\_\_\_

Interim Executive Director, Human Resources: \_\_\_\_\_ Date: \_\_\_\_\_

Approved: \_\_\_\_\_ Not Approved: \_\_\_\_\_