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. Please note some providers charge a fee for completion of this form. 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 _____

Executive Director, Human Resources: _____ Date: _____

Approved: _____ Not Approved: _____