

University of Tennessee Space Institute (UTSI)

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 UTSI Human Resources, 411 B.H. Goethert Parkway, Tullahoma, TN 37388-9700 (fax:931-393-7268). The UTSI 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)

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

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

- 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 UTSI Human Resources Office, 411 B.H. Goethert Pky, Tullahoma, TN 37388-9700. 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

(Human Resources Signature)

Employment Date: _____

(Date)

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