(UT Health GME) Request for Family or Medical Leave

Name:____ Date of Request:_____________________________
(30-day notice if applicable)

Title:___________________________________Unit/Dept:____

EMPLID:_________________________ Phone: _________________Shift: ___________________

Percentage of Worktime: ___________________ Supervisor's Name:____________________________________

Address (while you are on leave):____

Telephone Number (while you are on leave): (____) ____

I request permission to be absent from _______________through ________________ *OR*
beginning date *ending date*

I request to be absent on an intermittent or reduced schedule basis from _______________ through _______________
beginning date *ending date*

NOTE: If leave request is for medical reasons, you must complete a CERTIFICATION OF PHYSICIAN OR PRACTITIONER FORM.

REASON FOR LEAVE: I am requesting family or medical leave for the following reason(s):

1. ☐ For the birth of my son/daughter and care after the birth.**
2. ☐ For the adoption or foster care of my son/daughter.**
3. ☐ For the serious health condition of my spouse, child (under 18 years of age) or parent.**
4. ☐ For my own serious health condition (which makes me unable to perform the essential functions of my job).

**COMPLETE FAMILY RELATIONS INFORMATION BELOW. See Page 2 for definitions.

FAMILY RELATIONS INFORMATION

Spouse Information (all employees must complete):

a. Do you have a SPOUSE employed by UTHSC-H? YES_____ NO_____ (if yes, answer b and c)

b. Indicate your spouse's EMPLID:_______________________________

c. Has your spouse taken family/medical leave within the past 12 months? YES_____ NO_____
(Note: If your spouse is also employed by UTHSC-H, both you and your spouse are limited to 12 workweeks COMBINED if your leave request is for birth or adoption reasons.)

Family Member Information (related to your leave). {Omit if leave is for birth/adoption reasons}:

Name:_____________________________________ Relationship:___________________ Age:__________________

Please Read Carefully Before Signing, I acknowledge the above information and all other information otherwise given by me (pertaining to family or medical leave), is TRUE, COMPLETE, and NOT MISLEADING in any way. I understand that any INCORRECT, INCOMPLETE or FALSE STATEMENTS furnished by me may result in sufficient cause for denial of leave and/or disciplinary action. I hereby grant permission for UTHSC-H to verify information furnished by me regarding family or medical leave. I acknowledge that I have READ and UNDERSTOOD the information on this document, and agree to comply with the rules and regulations outlined therein. I also understand that my employment with UTHSC-H may be terminated upon my failure to return to work on the expected date of return or upon the expiration of all my FMLA and leave entitlements.

____ ____

Employee Signature/Date Supervisor's Signature/Date

☐ Approved ☐ Denied

- Original to Program File 1 Copy to Employee 1 Copy to GME File

Instructions:

1. All employees requesting family or medical leave must complete the information on page one.

2. If leave request is for medical reasons, the employee must provide a CERTIFICATION OF PHYSICIAN OR PRACTITIONER FORM. The certification form must be submitted to supervisor within 15 calendar days following initial request.

3. All Leave request forms must have a departmental authorized signature for approval.

Definitions:

Spouse - Is defined as a husband or wife in accordance with the law in the State of Texas. Unmarried domestic partners do not qualify for family leave.

Parent - Includes biological parents and individuals who acted as your parents, but does not include parents-in-law.

Son/Daughter - Includes biological, adopted, foster children, stepchildren, legal wards, and other persons for whom you act in the capacity of a parent and who is under 18 years of age, or over 18 years of age but incapable of caring for themselves because of mental or physical disability.

Serious Health Conditions - Examples include heart attacks, heart conditions, most cancers and back conditions requiring extensive therapy or surgical procedures, strokes severe respiratory conditions, appendicitis, pneumonia, emphysema, severe nervous disorders, injuries caused by serious accidents (on or off the job), pregnancy, severe morning sickness, need for prenatal care, childbirth, recovery from childbirth and miscarriages.

Please Read Carefully:

I understand that my annual leave and sick leave balances (if applicable) will be applied towards my family or medical leave. I understand that I will be required to submit a completed CERTIFICATION OF PHYSICIAN OR PRACTITIONER FORM if the reason for my leave is for a serious health condition of my spouse, child, parent or myself.

If I take leave because of my own serious health conditions, I must provide my supervisor with a CERTIFICATION OF FITNESS FOR DUTY form from my physician or practitioner. I may be required to take a FITNESS FOR DUTY examination if there is probable reason that I cannot perform the essential functions of my job. I understand that if the duration of leave (or amount of time on the initial request) changes, it is my responsibility to contact my supervisor regarding the status change and intent of my return to work.

I agree to continue paying my portion of the premium for my MEDICAL INSURANCE BENEFITS and at the same time UTHSC-H will continue to contribute its share of the premium cost. If I fail to pay my premium by the 20th of the month, UTHSC-H reserves the right to CANCEL my medical insurance benefits. If UTHSC-H cancels my health coverage, my health insurance benefits will be restored the day I return to work. They will be restored at least at the same level and terms to which I was provided when leave commenced.

If I fail to return to work after a period of unpaid leave, and UTHSC-H has paid its share of the premium for maintaining my health insurance, UTHSC-H reserves the right to recover the premiums that were paid to me during my leave.

I understand that if my leave request is denied, I may protest the decision on an informal basis to my supervisor or department head, or file a grievance in accordance with UTHSC-H's Grievance Policy.

I understand there is no expectation for me to perform any work related tasks while I am on Family Medical Leave.

I understand that failure to return to work at the end of my leave period may be treated as resignation unless an extension has been agreed upon and approved in writing by my supervisor.