

REQUEST FOR PARENTAL LEAVE

Return this form to Human Resources or Fax (817)735-0127. Request for Parental Leave must be made, if practical, at least 30 days prior to the date the requested leave is to begin.

EMPLOYEE INFORMATION (To be completed by the employee – Please print)	
Name:	Employee ID#:
Job Title:	Date of Hire:
Home Address:	Department:
Contact #:	Supervisor:
3. Reason for requesting leave. Check one: a. <input type="checkbox"/> Birth of a child b. <input type="checkbox"/> Placement of a son or daughter for adoption/foster care	
6. Effective Date of Leave Request:	7. Date of anticipated return to work:
8. Are you requesting leave on an intermittent or reduced work schedule? <input type="checkbox"/> Yes* <input type="checkbox"/> No <small>*If yes, please provide a completed Certification of Health Care Provider form justifying the necessity for intermittent leave. On a separate sheet give a schedule of when you anticipate you will be unavailable for work.</small>	
9. I understand that I will use all available paid leave. Leave will be paid only if employee has sufficient and appropriate accruals to cover part or all of the absence.	
Employees seeking leave <u>must</u> have a health care provider complete the Certification of Health Care Provider Form and return it to the HR Department <u>within 15 days</u>, or as soon as practicable. Leave may be delayed until a completed Certification of Health Care Provider Form is provided. Employees seeking to return to work after a leave must complete the Return to Work Medical Certification Form before they will be allowed to resume work. Employees may not be permitted to resume any position until a completed Return to Work Medical Certification Form is provided.	

EMPLOYEE AGREEMENT

I understand that failure to return from the approved Parental Leave within the agreed upon timeframe may constitute a voluntary termination. I have read the Family and Medical Leave and Parental Leave policy and am aware of my responsibilities that I will need to provide necessary medical documentation for any period of Parental Leave requested and that I will need to notify my supervisor and Human Resources immediately if any of the information above should change. I certify that the information above is accurate. I understand that if any of my leave is unpaid as part of my Parental Leave, I will be responsible for contacting the UNT System Human Resources Benefits Section at (817) 735-7680 for information on payment of my share of the premiums.

I understand that while on Parental leave I will contact the Human Resources Department after I have been on leave for 30 calendar days and at the end of each 30-day period afterwards.

Employee Signature:	Date:
Supervisor's Signature:	Date: