REQUEST FOR FAMILY AND MEDICAL LEAVE

Return this form to UNT System Human Resources – FMLA or Fax 817-735-5495. Request for Family or Medical 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: **Contact #:**	**Department:** **Supervisor:**

3. Reason for requesting leave. Check one:

a. ☐ Birth of a child
b. ☐ Placement of a son or daughter for adoption/foster care
c. ☐ Care for child, spouse, parent, or legal dependent with a serious health condition (be sure to answer #4 and #5)
d. ☐ Serious health condition which makes me unable to perform the functions of my position

4. If 3c is checked, please indicate: ☐ Child ☐ Parent ☐ Spouse ☐ Legal Dependent

5. If 3c is checked, please provide Name and Address of Family Member:

_____

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? ☐ **Yes*** ☐ **No**

*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.

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 because of Reason 3c or 3d *must* have a health care provider complete the Certification of Health Care Provider Form and return it to the HR Department ***within 15 days***, 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 because of Reason 3d, ***also*** must complete the Return to Work Medical Certification From 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 Family and Medical Leave within the agreed upon timeframe may constitute a voluntary termination. I have read the Family and Medical Leave policy and am aware of my responsibilities that I will need to provide necessary medical documentation for any period of FMLA 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 Family Leave, I will be responsible for contacting the UNT System Human Resources Benefits/FMLA Coordinator at 817-735-5495 for information on payment of my share of the premiums

I understand that while on FMLA 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:**