THE UNIVERSITY OF TEXAS AT DALLAS
Request for Family or Medical Leave

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

UTD ID:_____________________________ Extension:____________________ Shift: ________________
if applicable

Number of hours worked per week: ________ Supervisor's Name: ______________________________________

Have you worked for UT Dallas for the past 12 months? YES ☐ NO ☐
If no, are you a DIRECT TRANSFER from another STATE OF TEXAS agency/institution? YES ☐ NO ☐
If yes, what were the dates of employment? Start Date: ________________End Date: _______________
(Note: Prior to the commencement of your leave, you must have had at least 12 months total service with the State of Texas to be eligible for family or medical leave).
Have you taken a family or medical leave in the past 12 months? YES ☐ NO ☐ If yes, how many work days? __________

Address (while on leave):____

Telephone Number (while on leave):____

I request permission to be absent continuously/intermittently (circle one) from: _______________ through _________________

Note: If leave request is for medical reasons, you must provide a Certification of Health Care Provider.

REASON FOR LEAVE:
I am requesting family or medical leave for the following reason(s):
- ☐ For the birth of my son/daughter and care after the birth. **
- ☐ For the adoption or foster care of my son/daughter. **
- ☐ For the serious health condition of my spouse, child (under 18 yrs. of age) or parent. **
- ☐ For my own serious health condition (which makes me unable to perform the essential functions of my job).
- ☐ For qualifying exigencies arising out of the fact that my spouse, son, daughter, or parent is on active duty or call to active duty status as a member of the National Guard or Reserves in support of a contingency operation. **

**COMPLETE FAMILY RELATIONS INFORMATION BELOW.

FAMILY RELATIONS INFORMATION:
Spouse Information (all employees must complete):
a) Do you have a SPOUSE employed by UT Dallas? YES ☐ NO ☐ If yes, complete b) and c).
b) Indicate your spouse's UTD ID: ______________________________
c) Has your spouse taken family/medical leave within the past 12 months? YES ☐ NO ☐
(Note: If your spouse is also employed by UT Dallas, you are both limited to 12 workweeks COMBINED if your leave request is: 1) for birth or adoption reasons, or 2) for the serious health condition of your parent.)

Family Member Information (related to your leave) {omit if leave is for birth/adoption reasons}:
Name:____Relationship:_____________________________
If applicable, indicate your CHILD'S Date of Birth:______________________ Age:___________________
If your child is over 18yrs. old, is he/she mentally or physically DISABLED? YES☐ NO ☐

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, MISLEADING or FALSE STATEMENTS furnished by me may result in sufficient cause for denial of leave and or disciplinary action. I hereby grant permission for UT DALLAS to verify information furnished by me regarding family or medical leave. I acknowledge that I have READ and UNDERSTOOD the information on the REVERSE SIDE OF THIS DOCUMENT, and agree to comply with the rules and regulations outlined therein.

____ ____
Employee's Signature/Date Supervisor's Signature/Date

Original to Department Copy to Human Resources Copy to Employee

Revised February 2009

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Instructions:

1) All employees requesting family or medical leave must complete information on front page.
2) If leave request is for medical reasons, the employee must provide a Certification of Health Care Provider documenting the necessity for the medical leave. Failure to do so may result in denial of FMLA.

Definitions:

Spouse – 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.

Qualifying exigencies – Examples include attending military-sponsored functions, making appropriate financial and legal arrangements, and arranging for alternative childcare.

Please Read Carefully:

I understand that eligible employees must first use all available and applicable paid vacation and sick leave while taking family and medical leave, with the exception of an employee who is receiving temporary disability benefits or workers' compensation benefits and is not required to use paid leave while receiving those benefits. I may not use any annual or sick leave accruals and subsequent accruals, which begin with the first day of the month following commencement of my leave, until after a return to duty. I understand that I will be required to provide a Certification of Health Care Provider if the reason for my leave is for a serious health condition of my spouse, child, parent or me.

If I take leave because of my own serious health conditions, **BEFORE I REPORT TO WORK**, I must provide my supervisor with a **STATEMENT** from my health care provider that I am fit to resume work. I may be required to take a **FITNESS FOR DUTY** examination if there is a probable reason that I cannot perform the essential functions for 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 UT Dallas will continue to continue its share of the premium cost. If I fail to pay my premium by the 1st of the month, UT Dallas reserves the right to CANCEL my medical insurance benefits. If UT Dallas cancels my health coverage, my health insurance benefits will be restored the day I return to work. They will be restored to the same level and terms to which I was provided when leave commenced.

When an employee returns to work under the act, they are entitled to be restored to the same position held when the leave started, or to an equivalent position with equivalent pay.

If I FAIL TO RETURN TO WORK after a period of unpaid leave, and UT Dallas has paid its share of the premium for maintaining my health insurance, UT Dallas' reserves the right to recover the premiums that were paid to me during my leave. I understand that a failure to return to work at the end of my leave period may be treated as a resignation unless an extension has been agreed upon and approved by my supervisor and/or Human Resources Management.