RESET

THE UNIVERSITY OF MEMPHIS

Request for Medical Leave
This request should be returned to:
Human Resources, 165 Administration Building

The employee should complete this form when requesting medical leave (paid or unpaid) for more than three (3) or more consecutive days or for an ongoing medical event. Submission of this form does not guarantee approval.

- **Contact Human Resources in 165 Administration Building or at 901-678-3573 for additional required forms.**
- **Employee must notify his/her department of need for leave of absence.**

SECTION I: EMPLOYEE INFORMATION

Employee name: _____ U#: _____

Work phone: _____ Home phone: _____

Department: _____ Department Head name: _____

Supervisor name: _____ Supervisor phone: _____

Is your spouse a University of Memphis employee? ☐ Yes ☐ No

If yes, provide spouse name and department: _____

SECTION II: LEAVE REQUEST

The purpose of this leave request is for (please check one):

☐ Serious illness of employee
☐ Serious illness of spouse
☐ Serious illness of parent
☐ Serious illness of child (date of birth _____)
☐ Other
☐ Maternity Leave (due date _____)
☐ Paternity Leave (due date _____)
☐ Adoption (due date _____)
☐ Qualifying Exigency Leave
☐ Military Caregiver Leave

Requested start date: _____ Anticipated end date: _____

Please give a brief description of why leave is needed. If intermittent leave or a reduced work schedule is requested, please provide expected schedule. This information will be maintained in a confidential medical file.

_____
_____
_____
_____

FMLA **may be** designated to an employee, if they meet two of the following criteria's:

1. A serious illness of employee, spouse, parent, or child under 18 years of age or for an ongoing medical event as it may relate to FMLA or for maternity, paternity, adoption, qualifying exigency or military caregiver leave.
2. Employed by the UofM for one (1) year and worked 1250 hours in the preceding year.

SECTION III: EMPLOYEE SIGNATURE

I understand that I am required to complete a **FMLA Leave Certification of Health Care Provider form** and submit the form to Human Resources before my leave commences. The form should be returned to Human Resources within 15 calendar days. If I am not able to return the form within the allowed time frame, I will contact Human Resources for assistance. The Certification of Health Care Provider form is held in a confidential medical file. It is not part of the HR personnel file.

I understand that if my leave is approved, my time away from work will be charged against my 12 week leave maximum under FMLA. Upon approval of this requested leave, I am required to utilize all paid time available to me prior to going into an unpaid leave status. In the event that I go into an unpaid status while on leave, I understand that I must contact the Human Resources office to make arrangements to pay my portion of health insurance premiums.

I have ☐ have not ☐ notified my department.

I certify to the best of my knowledge that all of the information on this form is correct.

Employee signature: _____ Date: _____

SECTION IV: HUMAN RESOURCES

HR Representative Signature: _____ Date: _____