Request for Family or Medical Leave

*A**request for family or medical leave should be made 30 days prior to the anticipated date of the requested leave event.*

**Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Office:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Status:** *Full-time\_\_\_\_\_\_\_\_\_\_\_ Part-tim*e\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**TNCC Hire Date:** \_\_\_\_\_\_\_\_\_\_\_ **State Hire date:** \_\_\_\_\_\_\_\_\_\_\_

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

\_\_\_\_\_\_\_ BIRTH OF A CHILD\* Expected date of delivery \_\_\_\_\_\_\_\_\_\_\_

Leave to start: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Expected return date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_ PLACEMENT OF A CHILD WITH ME FOR ADOPTION OR FOSTER CARE\*

Leave to start: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Expected return date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_ TO CARE FOR MY SPOUSE, CHILD, OR PARENT THAT HAS A SERIOUS HEALTH CONDITION\*

Leave to start: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Expected return date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_A SERIOUS HEALTH CONDITION THAT MAKES ME UNABLE TO PERFORM MY WORK DUTIES\*

*Please describe:*

Leave to start: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Expected return date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_FOR OTHER REASONS\*

*Please describe:*

Leave to start: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Expected return date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_ Request for intermittent leave schedule *(subject to agency's approval)*

Schedule requested:

\_\_\_\_\_\_\_ Request for reduce schedule *(subject to agency's approval)*

Schedule requested:

**\*A physician's certification or other documentation may be required**.

Have you taken family or medical leave in the past calendar year? \_\_\_\_\_ Yes \_\_\_\_\_\_ No

If yes, how many work days? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Can be utilized only if you or your spouse, child, or parent has a serious health condition. Definition of child is as follows:

*A child is a biological, adopted or foster child, a stepchild, or legal ward, or a child of a person standing in place of the parent. The child must either be under age 18 or be age 18 or older and incapable of self-care because of a mental or a physical disability.*

**I understand and agree to the following provisions: (Check all that apply)**

\_\_\_ I have worked for state government (agency, if wage employee) for at least 12 months and for at least 1250 hours in the previous 12 months.

\_\_\_ I have the option of using paid leave for absences covered under family and medical leave. I understand TNCC can designate such leave as family and medical leave.

\_\_\_ If the leave will be unpaid (LWOP), I understand it will be my responsibility to pay my portion of the health care premium to my agency on the first day of each month. Additionally, I understand that while on LWOP or after 90 consecutive calendar days of paid leave I will not accrue annual or sick leave hours.

\_\_\_ If after 12 weeks of leave, I do not return to work on the date intended, TNCC may seek to recover the Commonwealth's health insurance contributions for the period I was on leave without pay.

\_\_\_ At the end of family and medical leave, I normally will be reinstate to my original position (or equivalent position) before the leave began unless I hold a key position.

**Employee Signature:**

**Date:**

**Full Day(s) Leave**:

Supervisor's Signature:

Date:

Vice President’s Signature:

Date:

**Intermittent Leave:**

Supervisor's Signature:

Date:

Vice President’s Signature:

Date:

**Reduced Schedule Leave**:

Supervisor's Signature:

Date:

Vice President’s Signature:

Date:

Human Resources Manager's Signature:

Date: