



Application for Family Leave Pool

Part 1: Completed by the Employee

Name:	Department:
Job Title:	Supervisor:
Email:	Contact #:
3. I request an award from the Family Leave Pool to be used for: Please indicate: <input type="checkbox"/> Birth of a Child <input checked="" type="checkbox"/> Baby Bonding <input checked="" type="checkbox"/> Serious Health Condition <input checked="" type="checkbox"/> Pandemic Related Reasons <input checked="" type="checkbox"/> Placement of a Foster Child or Adoption under 18 years of age <input checked="" type="checkbox"/> Placement of any Person 18 years of Age or Older Requiring Guardianship <input checked="" type="checkbox"/> Previous Donation to the Family Leave Pool	
If Serious Health Condition: <input checked="" type="checkbox"/> My Own Serious Health Condition <input checked="" type="checkbox"/> Family Member's Serious Health Condition	
4. Effective Date of Leave Request:	5. Date of anticipated return to work:

Documentation Required for Final Processing of Application:

1. For birth of a child: Physician or practitioner certification form for employee/family member.
2. Bonding – in the first year after child's birth: Birth certificate to verify use of bonding within first year.
3. Serious illness of employee or immediate family member or the employee, including pandemic related illness: Physician or practitioner certification form for employee/family member.
4. Placement of foster child or adoption of a child under 18 years of age: Adoption order.
5. Placement of any person 18 years of age or older requiring guardianship: Placement order.
6. Serious illness of an immediate family member or the employee, including pandemic related illness: Physician or practitioner certification form for employee/family member.
7. An extenuating circumstance created by an ongoing pandemic, including providing essential care to a family member:
 - A. Physician or practitioner certification form for employee/family member.
 - B. Proof of closure of school or daycare.
 - C. Persons not listed on TWU employee insurance provided by ERS will require documentation that establish the relationship. Acceptable documentation examples are provided in the [Dependent Eligibility Chart](#).

EMPLOYEE AGREEMENT:

I have read the Family Leave Pool policy and by my signature below I certify that this application meets the requirements of that policy. I understand that I must meet the requirements set out in the Family Leave Pool policy and that the decision of the Family Leave Pool Administrator is final. I understand that I must authorize my health care provider(s) to release all necessary information requested on the Family Leave Pool Health Care Provider Medical Certification form and any charges I incur for the completion of this document will be at my expense.

Employee Signature:	Date:
*If applicable, name of immediate family member:	* If applicable, relationship to employee:

Part 2: Completed by the Family Leave Pool Administrator

FLP hours previously awarded for this illness:	Date Additional Information Requested:	Date Additional Information Received:
Eligible for FLP: Yes No	Number of Days Approved:	Date employee/Dept notified:

Submit completed forms and required documentation to: **The Office of Human Resources**
Benefits Department: Fax: (940) 898-3566 or scan and email to: Benefits1@twu.edu