**TEXAS WOMAN'S UNIVERSITY**

**REQUEST FOR PARENTAL LEAVE**

Employees ineligible for FMLA leave are entitled to a parental leave of absence, not to exceed twelve weeks, for the birth of a natural child or the adoption of a child. This period begins with the date of birth or the adoption or foster care placement with the employee of a child. Employees may use available compensatory time, vacation or leave without pay for this period. Sick leave is strictly limited to those situations clearly falling within the definition of sick leave**.**

**PART I: TO BE COMPLETED BY EMPLOYEE**

Please complete the application and forward it to Human Resources. To be considered, employee and supervisor signatures are required on the application and, if applicable, medical documentation provided by a medical provider.

Employee Name: _____ Dept.: _____ Job Title: _____

Supervisor: _____ Employment Date: _____

**REASON FOR LEAVE:**

☐ Adoption or foster care of a child. ☐ Birth, bonding and/or care of a child.

Amount of time requested: _____ Date leave will begin: _____

Date of anticipated return to work: _____

I understand that during Parental leave, I am required to pay my share of insurance premiums for which I am ordinarily responsible. If I receive a paycheck, benefits will be deducted. If I am not receiving a check I understand that I will be billed for my share of insurance premiums. If billed premiums are not paid within 30 calendar days of the coverage month, my insurance will be cancelled effective the last day of the month premiums were paid.

I acknowledge that I am required to provide documentation from my medical provider to support the portion of my leave to be paid by sick leave.

**Employee Signature:**

I attest that the information noted above is true and accurate to the best of my knowledge and that I have full intention of returning to work. I understand that I am responsible for obtaining information from my health care provider to provide additional or clarifying information that would assist in the determination of my qualifying for benefits. In compliance with HIPAA Medical Privacy Rules, my signature indicates my permission for the health care provider to release any and all information as requested on this form for clarification of individually identifiable health information.

| _____ | _____ | _____ |
|---|---|---|
| Employee's Signature | Contact Phone Number | Date |

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**PART II: TO BE COMPLETED BY MANAGEMENT**

I acknowledge this employee's request for Parental Leave.

| _____ | _____ | _____ |
|---|---|---|
| Supervisor Signature | Contact Phone Number | Date |

Please return to the Office of Human Resources for determination that the request meets criteria for Parental Leave