TEXAS WOMAN'S UNIVERSITY
REQUEST FOR FAMILY/MEDICAL LEAVE

PART I: TO BE COMPLETED BY EMPLOYEE

Complete the application and forward it to Human Resources. The request will not be considered without all required signatures on the application and, if applicable, the medical certification form.

Employee Name: _____ Dept: _____ Job Title: _____

Supervisor: _____ Employment Date: _____

REASON FOR LEAVE: (Please refer to TWU Policy 3.24 for definition of "immediate family" and "next of kin".)

☐ Because of my own serious health condition which makes me unable to perform the essential functions of my position.

☐ In order to care for a member of my immediate family with a serious health condition.

☐ Because a member of my immediate family has been called to military active duty in support of a contingency operation.

☐ In order to care for a military service member of my immediate family or next of kin with a serious illness or injury incurred in the line of duty while on active duty.

☐ 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 FMLA leave, I am required to pay my share of insurance premiums for which I am ordinarily responsible. If I receive a paycheck large enough to accommodate premiums, benefits premiums 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. While on FMLA, the State will continue to pay the State's portion of my insurance. Any coverage other than member only health insurance and member only basic life could be cancelled for non-payment.

I acknowledge that if I do not return from FMLA leave for at least one calendar month due to reasons not provided for in the Family and Medical Leave Act, then **FMLA does not apply to this period of leave and I am required to reimburse all insurance premiums paid by TWU during any periods of unpaid** FMLA leave. If reimbursement is not made, insurance coverage will be canceled the first of the month following the exhaustion of paid leave.

Employee Signature:

I have reviewed the applicable TWU Policy 3.24 for the Family Medical Leave Act. 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

PART II: TO BE COMPLETED BY MANAGEMENT

I acknowledge this employee's request for FMLA. I have reviewed the applicable TWU Policy 3.24 for the Family Medical Leave Act and recommend that this application be forwarded to the FMLA administrator for determination.

_____	_____	_____
Supervisor's Signature	Contact Phone Number	Date

Please return to the Office of Human Resources for determination that the request meets criteria for FMLA.

Revision
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