UT Southwestern Medical Center

INITIAL REQUEST ☐
AMENDED REQUEST ☐

Family Medical Leave Request

EMPLOYEE INFORMATION: **Please print and complete all sections to avoid processing delays.**				
Name:		○ Male ○ Female	Person Number:	
Job Title:			Home/Cell Phone:	
Dept.:			Work Phone:	
Do you have a UT Southwestern email address? ○ Yes ○ No Please also provide an alternate email address:				
Marital status: ○ Single ○ Married		Spouse's name:		
Does your spouse work for UT Southwestern OR any other UT System institution? ○ Yes ○ No				
Employment status: ○ Full time ○ Part time ○ Other _____		Total hours scheduled per week: _____		
What are your regularly scheduled days and total hours per day: S _____ M _____ T_____ W_____ TH_____ F_____ S _____ Other:_____				
Have you worked for UT Southwestern Medical Center for the past 12 months? ○ Yes ○ No If no, have you been employed by a State of Texas agency within the past 7 years? ○ Yes ○ No If yes: Agency_____ Dates of Service: _____				

ANTICIPATED TIMING AND DURATION OF LEAVE: **Check all that apply**		
☐ Continuous Block of Time ☐ Both Continuous and Intermittent Leave* *Note: For Both Continuous & Intermittent Leave, also complete the Intermittent Leave section below.*	Estimated start date of leave:	Estimated date of return to work:
☐ Intermittent Leave*	Requested start date of intermittent leave:	Requested end date of intermittent leave:
☐ Reduced Schedule*	Estimated start date of reduced schedule:	Estimated end date of reduced schedule:

Intermittent/Reduced schedule leave for **birth of child is only approved on a case-by-case basis.*

FMLA QUALIFYING REASON FOR LEAVE

Check only one. A *new* FMLA Request Form is needed for each separate FMLA qualifying reason.
For more information regarding FMLA-qualifying reasons and the definitions of "spouse," "parent," "child" and "next of kin", please refer to EMP-256 Family Medical Leave

○ Employee's serious health condition (not work related)	○ Employee's serious health condition- **work- related injury or occupational disease** as defined by EMP-303 Workers' Compensation Insurance Program
○ Employee's pregnancy/birth of child/bonding (mother) Anticipated date of birth:_____	○ Birth of employee's child/bonding (father) Anticipated date of birth:_____
○ Adoption of employee's child Anticipated date of adoption:_____	○ Foster care placement of employee's child Anticipated date of placement:_____
○ Care for employee's **spouse** with a serious health condition	○ Care for employee's **parent** with a serious health condition ☐ Mother ☐ Father
○ Care for employee's **minor** child with a serious health condition. Child's date of birth:_____	
○ Care for employee's **adult** child* with a serious health condition. Child's date of birth:_____ *If the child is 18 or older, is/will the child be incapable of self-care because of a mental or physical disability? ○ Yes ○ No	
Military Qualifying Exigency ○ Spouse ○ Child ○ Parent	Military Caregiver Leave ○ Spouse ○ Child ○ Parent ○ Next of kin

IMPORTANT INFORMATION

- All FMLA Request Forms must be provided to the employee's supervisor and/or department administrator for final completion before submission to Leave Administration.
- Leave Administration will respond to the FMLA Request via the employee's UT Southwestern email and/or home mailing address noted in PeopleSoft HCM within 5 business days of receipt (absent extenuating circumstances). UT Southwestern email accounts can be remotely accessed at: https://mail.swmed.edu
- ***Medical certifications should be provided to Leave Administration only and not the department.***
- Health care providers should retain copies of any medical certifications submitted.
- Ongoing chronic conditions involving a need for continual intermittent leave must be recertified at least annually.
- UT Southwestern may request an updated Health Care Provider's Certification every 30 days, as permitted by the FMLA.
- Please refer to EMP- 256 Family and Medical Leave, EMP- 256P-01 Managing Family and Medical Leave, and the Leave Administration intranet site for more information.

I understand and acknowledge that UT Southwestern will verify information furnished by me and by my health care provider regarding my Family Medical Leave Request. By my signature below, I affirm that the information provided herein, and all other information I provide to UT Southwestern pertaining to my Family and Medical Leave request, is accurate, complete and not misleading in any way. **I understand that knowingly providing UT Southwestern false or misleading information relating to my Family and Medical Leave request may result in delay or denial of FMLA leave and could result in disciplinary action, up to and including termination or non-renewal of appointment.**

Employee Signature: _____ Date: _____

DEPARTMENT'S SECTION TO COMPLETE AND IMMEDIATELY FAX TO 469-694-8424

A signature is not an approval, but only an acknowledgement of the FMLA request and the minimum hours worked in the previous 12 months.
Leave Administration determines eligibility for FMLA leave and will issue a written notice of approval or denial of all FMLA leave requests.

Has the employee worked a minimum of 1,250 hours within the 12 months immediately preceding the date that leave would begin? ○ Yes ○ No

(e.g., If an employee requests to begin leave on 5/4/21, confirm if he/she has worked at least 1,250 hours within the 12 month period of 5/4/20 – 5/3/21. For purposes of FMLA eligibility, "hours worked" does not include holiday, sick, vacation leave or other leave granted pursuant to University policies.)

Supervisor's name (printed):	Extension:
Supervisor's signature:	Date of signature:
Dept. Administrator's name (printed):	Extension:
Dept. Administrator's signature:	Date of signature: