DYERSBURG STATE COMMUNITY COLLEGE
REQUEST FOR FAMILY AND MEDICAL LEAVE

NAME:_____ Employee ID #_____

DEPARTMENT:_____SUPERVISOR:_____ PHONE:_____

LENGTH OF LEAVE:_____DATE LEAVE BEGINS:_____EMPLOYMENT DATE:_____

If spouse is employed by state:

NAME OF SPOUSE:_____SSN:_____

REASON FOR LEAVE: (Completed Certification of Health Care Provider form may be required.)

1. DUE TO SERIOUS ILLNESS OF:

_____EMPLOYEE _____PARENT _____SPOUSE _____CHILD (Age of child_____)

2. _____BIRTH: Due date:_____

3. _____ADOPTION OR FOSTER CARE PLACEMENT:

Name of child:_____DOB:_____

Date of Adoption/Placement:_____
(Please provide copy of adoption/placement papers and/or certificate.)

INTERMITTENT LEAVE:_____YES _____NO REDUCED WORK SCHEDULE:_____YES _____NO
(Please attach copy of approved schedule.)

I understand the following:

(1) I may be required to furnish an additional, completed Certification of Health Care Provider form for continuation of FMLA leave.

(2) This Institution will pay the employer portion of the group medical insurance during any approved unpaid FMLA leave, provided I pay the employee portion in accordance with the payroll deadline date. All other insurance plans that I wish to continue during the FMLA period must be fully paid by me.

(3) If I elect not to continue insurance coverage during the FMLA leave period, I must notify the insurance preparer in writing prior to the beginning of the leave. If plans are voluntarily canceled prior to the leave, I must request that coverages be reinstated within 31 days of my return to work. Premiums that would have been due during the FMLA leave for optional plans will be deducted from my paycheck.

(4) If I do not return to work, I will be responsible for reimbursing the University for employer premiums paid in my behalf during any unpaid FMLA leave period. I will not have to repay premiums if I do not return to work for the following reasons: a) continuation, recurrence, or onset of a serious health condition of myself or an immediate family member or b) other circumstances beyond my control (not voluntary).

(5) If my period of leave continues beyond the twelve (12) workweeks provided in the Family and Medical Leave Act of 1993, I must notify the insurance preparer in writing if I wish to drop coverage for the remainder of the leave period. This notification must be received no later than the last day of the month in which my insurance is continued under the provisions of FMLA leave.

(6) I will not accrue leave or receive longevity payment while on leave without pay.

Employee Signature:_____ Date:_____

Supervisor/Department Head:_____ Date:_____
(Supervisor's signature)

_____ Date:_____
(Human Resources signature)

Approved:_____ Not Approved:_____

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PLEASE READ AND SIGN BELOW FOR MATERNITY, PATERNITY, OR ADOPTION LEAVE

MATERNITY LEAVE
(Due at least three (3) months in advance of leave)

Regular full-time female employees may be eligible for a period of up to four (4) months maternity leave in accordance with Tennessee Code Annotated 50-1-501 through 503 and the Family and Medical Leave Act TBR Policy 5:01:01:14. All provisions of the Sick Leave Policy 2D:05:01C shall apply to this period of absence. Sick leave shall be used for the period of medical disability only. Example: post-natal care – not to exceed (6) weeks unless further leave is required and certified by the health care provider.

Department Head shall notify the Department of Human Resources when leave actually begins. Commencement of leave, which must comply with provisions of Maternity Leave Procedure 2D:05:01E, begins when in the opinion of the attending physician the employee is no longer able to carry out her job duties due to her pregnancy.

By signature below, I certify that I have at least twelve (12) months consecutive, full-time employment with Dyersburg State. I understand that I may not pursue any other employment during my leave including filling out applications or submitting resumes. I also understand that accrued sick leave may be used only for the period of medical disability.

PATERNITY LEAVE

Regular employees may use up to thirty (30) working days of sick leave if their balance is sufficient.

ADOPTION LEAVE

Regular full-time and part-time employees may be eligible for a period of up to four (4) months adoption leave in accordance with the Tennessee Board of Regents Policy 5:01:01:02 and through the Family and Medical Leave Act TBR Policy 5:01:01:14. Since leave may be used for up to thirty (30) working days, if both parents are State employees, the aggregate amount of sick leave that may be used is thirty (30) working days.

_____ _____
Employee Signature Date

_____ _____
Department Head Date

APPROVED:

_____ _____
Human Resources Date