|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Name: |  | | Texas State ID Number: | |  |
| Department: | |  | Phone Number: |  | |

|  |  |
| --- | --- |
| **Reason for requested leave:** | |
|  | The birth of a child, or placement of a child with me for adoption or foster care.  My spouse works for the State of Texas and is taking FMLA for the birth or adoption of a child.  Yes  No  N/A |
|  | My own serious health condition. |
|  | Because I am needed to care for my  spouse;  child;  parent due to his/her serious health condition. |
|  | Because of a qualifying exigency arising out of the fact that my  spouse;  son or daughter;  parent is on active duty or call to active duty status in support of a contingency operation as a member of the National Guard or Reserves. |
|  | Because I am the  spouse;  son or daughter;  parent;  next of kin of a covered service member with a serious injury or illness. |

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **Date to begin leave:** |  | / |  | / |  |  |

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **Date of anticipated return to work:** |  | / |  | / |  |  |

|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Approximately how many hours of paid leave do you plan to use?** | | | | | |  | | |
|  | Sick |  | Vacation |  | State Comp Time | |  | FLSA Overtime | |

**Are you requesting leave on an intermittent or reduced leave schedule?**  Yes  No

**If “yes”, please give schedule of when you anticipate being available for work:**

|  |
| --- |
|  |

I understand that my leave may be delayed until I provide the required forms. I agree that while I am on leave, I will continue to pay my share of health insurance premiums, unless I elect to discontinue such coverage. I also agree that if I fail to return to work or return for less than 30 days after the leave period has ended, I will reimburse Texas State University for the cost of health benefits provided during my leave, unless I fail to return to work because of the continuation, recurrence, or onset of a serious health condition or because of other circumstances beyond my control. If I am unable to return to work because of a serious health condition, I will provide medical certification from the appropriate health care provider stating that I am unable to perform the functions of my position on the date that my leave expired or that I am needed to care for a covered relation because he/she has a serious health condition on the date that my leave expired.

If adding a child to health insurance, an enrollment form must be submitted to Human Resources within 30 calendar days of the date of birth or placement.

**Signatures:**

|  |  |  |  |
| --- | --- | --- | --- |
| Employee: |  | Date: |  |

|  |  |  |  |
| --- | --- | --- | --- |
| Supervisor: |  | Date: |  |

|  |  |  |  |
| --- | --- | --- | --- |
| Human Resources Representative: |  | Date: |  |