UNIVERSITY OF TEXAS AT EL PASO

Request for Family and Medical Leave (FMLA) Application

TO BE COMPLETED BY EMPLOYEE AND RETURNED TO:
Office of Human Resources
Administration Bldg. / Rm 216
500 W. University Ave. El Paso, Texas 79968
915-747-5815 Fax

In order to be eligible to take leave under the FMLA, an employee must have at least 12 months of total service with the State of Texas and have worked 1,250 hours during the 12 months prior to the start of leave.

Empl Name:	Empl ID:	Date Requested: / /
Empl Title:	Dept:	
Supervisor's Name:	Timekeeper's Name:	
Empl Address:		

Street/ Apt. # | City | State | Zip Code

Contact Phone #:	Preferred Method of Contact while on FML:	Email ☐	Telephone ☐	Mail ☐

TYPE OF LEAVE REQUESTED:

		Begin Date		Est. End Date
☐	**Intermittent** (recertification required every 6 months)	/ /	through	/ /
☐	**Continuous**	/ /	through	/ /

Note: If leave requested is for medical reasons, employee must complete a HEALTHCARE PROVIDER CERTIFICATION FORM

REASON FOR LEAVE: I am requesting Family or Medical leave for the following reason(s)

☐ **Serious Health Condition**

☐ **My Own** ☐ **Spouse** ☐ **Child** ☐ ***Parent**

My child, "under the age of 18 or 18 years of age or older and incapable of self-care because of a mental or physical disability." Age of child: _____

☐ ***Birth and Care of your Child**

☐ ***Adoption or Foster Care Placement**

My child, "under the age of 18 or 18 years of age or older and incapable of self-care because of a mental or physical disability." Age of child: _____

☐ ***Military Caregiver Leave** (Relationship to Service Member)

☐ **Spouse** ☐ **Parent** ☐ **Son/ Daughter** ☐ **Next of Kin**

☐ **Qualifying Exigency Leave**

Note: If none of the above apply, please contact a Benefits Representative in Human Resouces.

***FAMILY RELATIONS INFORMATION:** Complete family information below related to your leave

Do you have a SPOUSE employed by UT El Paso?	**Yes** ☐	**No** ☐
If **YES**, provide SPOUSE'S name:		

Note: If your spouse is also employed by UT El Paso, both you and your spouse are limited to 12 workweeks COMBINED if your leave request is for; 1) Birth or Adoption, or 2) Serious Health Condition of a Parent.

Please Read Carefully Before Signing. I acknowledge the above information and all other information otherwise given by me (pertaining to family or medical leave), is TRUE, COMPLETE and NOT MISLEADING in any way. I understand that any INCORRECT, INCOMPLETE, MISLEADING or FALSE STATEMENTS furnished by me may result in in sufficient cause for denial of leave and /or disciplinary action. I hereby grant permission for UT El Paso to verify information furnished by me regarding family or medical leave.

HUMAN RESOURCES

INSTRUCTIONS

1. **All employees requesting Family Medical Leave must complete information in order to assist the Office of Human Resources in determining eligibility.**
2. **The employee must provide a completed Certification of Health Care Provider to the Office of Human Resources within fifteen (15) calendar days following begin date of leave.**

DEFINITIONS:

Spouse -	Is defined as a husband or wife in accordance with the law in the State of Texas. Unmarried domestic partners do not qualify for family medical leave without supporting documentation.
Parent -	Includes biological parents and individuals who acted as your parents, but does not include parents-in-law.
Son/Daughter -	Includes biological, adopted, foster children, stepchildren, legal wards, and other persons for whom you act in the capacity of a parent and who is under 18 years of age, or over 18 years of age but incapable of caring for themselves because of mental or physical disability.
Serious Health Conditions -	An illness, injury, impairment, or physical or mental condition.
Continuous Leave -	Absence of **three consecutive work days** or longer, not separated by periods of work.
Intermittent Leave -	Is leave taken in separate blocks of time for a single illness or injury. Generally, employees must show the medical necessity for intermittent leave or a reduced leave schedule.
Recertification -	A request for the completion of an additional ***Certification of Health Care Provider.***

PLEASE READ CAREFULLY:

I understand that if my request is approved, I am entitled to utilize up to twelve (12) weeks of unpaid, job protected leave. I understand that my health care provider will be required to complete a ***Certification of Health Care Provider*** on behalf of my spouse, child, parent, or myself - prior to my request for leave is approved.

Upon approval of this requested leave, I am required to utilize all accrued sick and annual leave available to me prior to going onto an unpaid leave status, except in cases of work related illness or injury. I understand that any accrued paid time utilized will run concurrently with my request for FMLA leave.

I agree to continue paying my portion of the premium for my MEDICAL INSURANCE BENEFITS (if applicable); and, at the same time, UT El Paso will continue to contribute its share of the premium cost. If I fail to pay my premium by the twentieth (20^{th}) of each month to which I am on leave, UT El Paso reserves the right to CANCEL my insurance benefits. If UT El Paso cancels my coverage, benefits will be restored on the day I return, to the equivalent level I maintained prior to the commencement of my leave. I ACKNOWLEDGE, THAT IF I FAIL TO RETURN TO WORK after a period of unpaid leave, and UT El Paso has paid its share of the premium(s) for maintaining my health insurance, UT El Paso reserves the right to recover its share of premium(s) paid during my leave.

The University is committed to providing reasonable accommodations to staff and faculty members with documented qualifying disabilities. In accordance with the Americans with Disabilities of 1990 (ADA), and the Americans with Disabilities Act Amendments Act (ADAAA) of 2008 employees may request an ADA accommodation(s) to perform the essential function(s) of their job. If you would like to pursue such request, please contact the University's Equal Opportunity (EO) Office by emailing eoaa@utep.edu or calling (915) 747-5662.

I understand that any change(s) to the duration (from initial request) of my leave, status and/or intent to return to work, must be communicated directly to the Office of Human Resources.

I acknowledge that I have READ and UNDERSTOOD the information on this DOCUMENT, and agree to comply with the rules and regulations outlined therein.

_____ ___/___/___ _____ ___/___/___

EMPLOYEE SIGNATURE **DATE** **IMMEDIATE SUPERVISOR SIGNATURE** **DATE**