Texas Southern University

Office of Human Resources
3100 Cleburne St Houston TX, 77004 Phone 713-313-7521 Fax 713-313-4347

Important Notice: Unless your request for leave is unforeseeable, employees must submit request for FMLA leave and physician's certification at least 30 days in advance of their schedule leave to The Human Resources Department**.**

☐ Family & Medical Leave Request Form (completed by employee & supervisor)

☐ Certification of Health Care Provider (completed by physician)

☐ Return to work Certification (completed by physician & returned to HR)

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Family and Medical Leave/Parental Leave Request

Employee Information

Name: _____**T No**: _____

Preferred email Address: _____ **Phone #**:_____

Home Address: _____ **State**: _____ **Zip**: _____

Department: _____ **Supervisor's Name**: _____

Pay Type: ☐ Monthly ☐ Semi-Monthly

Months Worked Per Year: ☐12 month's ☐ 9 Months ☐ other

Request for: ☐ Family and Medical Leave ☐ Parental Leave

Leave Request Summary

Is this a joint application with a spouse who is a TSU employee? ☐ Yes ☐ No

Is the qualifying condition due to the birth of a child or care for a new born? ☐Yes ☐ No

Is the qualifying condition due to the adoption or state-approved foster care of a child? ☐Yes ☐No

Is the qualifying condition due to Military Leave: ☐Active Duty Leave ☐Military caregiver leave?

Active Duty: Qualifying exigency Relationship: Active duty paid vacation? ☐Yes ☐No

Military caregiver: Certification of health care provider: ☐ Yes ☐ No
Certification for next of kin? ☐Yes ☐No

Is the qualifying condition due to the serious health condition of a dependent? ☐Yes ☐No

Name: _____Relationship:_____DOB (if child) _____

Is the qualifying condition due to the serious health condition of the employee?

Date of event or onset of condition: ____/____/____ **Duration**: _____

Last day worked: ___/_____/_____

Are you requesting Intermittent Leave? ☐ Yes ☐ No

If yes, please provide Work/leave schedule: Duration of leave:

NOTE: Recertification will be required every 6 months for intermittent leave.

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Employee Section

I understand and agree to the following provisions:

-I certify that I have received the Health Care Provider Certification and must return it to HR within 15 calendar days or my FML will be denied.

-I must exhaust all sick, vacation, or other paid leave accumulations while taking FMLA leave. Once paid leave is exhausted I will be placed on leave without pay.

-After 12 weeks of FMLA have exhausted or the amount of approved leave has been used, if I do not return to work or contact my supervisor or manager on or before the date intended I will be considered that I abandoned my job.

-I will report periodically during the leave (at least once per week) to my supervisor on my leave status and intention to return to work.

-I must exhaust all sick, vacation, or other paid leave accumulations while taking FMLA leave. Once my paid leave has exhausted, I will be on leave without pay.

-I will receive the state credit for health insurance during the family or medical or parental leave and will be billed for any additional insurance premiums due. Should I fail to pay the additional premiums, my health insurance coverage will be changed to employee only level and optional coverage will be canceled. Continuation of group insurance is subject to the conditions and policies of ERS relating to coverage without pay.

-I must provide a release to work from my physician to HR following my leave, should I fail to do so my department may deny restoration of employment.

Employee Signature_____ Date: _____

Your rights under the Family and Medical Leave Act of 1993

The Family Medical Leave Act (FMLA) requires covered employers to provide up to 12 weeks (up to 26 weeks for military caregiver leave) of unpaid, job-protected leave to “eligible” employees for certain family and medical reasons. Employees are eligible if they have worked for a covered employer for at least one year and for 1,250 hours over the previous 12 months, and if there are eat least 50 employees within 75 miles.

When returning from FMLA leave most employees must be restored to their original or equivalent positions with equivalent pay, benefits and other employment terms.

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This section to be completed by your Department

Employee's Job Title: _____ FTE: _____ Hire Date: ___/_____/_____

Pay type: ☐ Monthly ☐ Semi-monthly **Months worked per year**: ☐ 12 months ☐ 9 months ☐ other

Last Day Worked: ____/____/_____

Vacation Balance as of last day: _____**Sick leave balance as of last day**: _____

Supervisor/Manager Signature_____ **Date**: _____/____/_____

-Any changes in the approved leave must be reported immediately to the Human Resources Department.

-A Personnel Action Form (PAF) is required to place the employee on family medical leave and should be submitted to Human Resources once family medical leave or parental leave commences (noting paid or unpaid leave)

-The employee will be given state premium sharing towards the cost of health insurance while on FMLA. The employee will be billed (or the amount will be deducted from any sick leave or vacation pay) for additional premiums in excess of the state premium sharing. Should the employee fail to pay the additional premiums, the health coverage will be changed to employee only leave and optional coverage will be terminated.

-Continuation of group insurance is subject to the conditions and policies of the "Employee Retirement System of Texas" relating to coverage while on leave without pay.

-Human Resources may request the department to provide leave records on the employee if necessary for processing benefits including but not limited to disability applications, workers compensation claims, and death claims.

Human Resources Section

Forms Received: ___/____/_____ Approved_____ Denied: ____

Reasons why denied:

_____

_____

_____

HR Signature: _____ Date: ___/___/_____

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FML PHYSICIAN'S INFORMATION RELEASE

To: _____
(Attending Physician)

RE: _____
(Printed Name of Patient)

This is an authorization to release all information pertaining to my condition to Texas Southern University, Office of Human Resources. Please return the original with the Certification of Healthcare provide form and retain a copy with your records.

I understand that this authorization can be revoked at any time by me in writing, but it will not be retroactive for information previously released in good faith.

Patient Signature: _____

Date signed: ____/_____/_____