Volunteer State Community College
Request for Family and Medical Leave

The employee should complete this form when requesting medical leave (paid or unpaid) for consecutive days or for an ongoing medical event. Submission of this form does not guarantee approval. Contact the Coordinator at 615-230-3591 or stop by Suite 139 Ramer Building for additional required forms.

PART I – EMPLOYEE INFORMATION

Name: _____ V #: _____ Phone #_____

Requested Leave Period: From_____ To: _____

Department: _____

Employment Date: _____ Name of Spouse if employed by state: _____

PURPOSE OF LEAVE REQUEST:

- ☐ Serious illness of employee
- ☐ Maternity (due date_____)
- ☐ Serious illness of spouse
- ☐ Paternity (due date_____)
- ☐ Serious illness of parent
- ☐ Adoption (date of adoption/placement_____)
- ☐ Serious illness of child (date of birth_____)
- ☐ Care of Military Service (name _____)
- ☐ Other_____

I UNDERSTAND THE FOLLOWING:

1. I may be required to furnish a completed Certification of Health Care Provider form in order for the Family and Medical Leave to be approved.
2. Volunteer State Community College will pay the employer portions of the group medical insurance during any leave of absence if approved under the Family and Medical Leave Act of 1993, provided I pay the employee portion in accordance with the payroll deadline date. All other insurance plans must be fully paid by me. If I drop the plan(s), I must notify the Office of Human Resources prior to beginning the leave. I must also request to reinstate coverage within thirty (30) days of my return from leave to retain eligibility without being required to prove insurability or having the pre-existing condition period imposed.
3. If I do not return to work I will be responsible for reimbursing the agency for employer premiums paid in my behalf during a period of unpaid leave.
4. That I will not accrue leave or receive retirement service credit while on leave without pay.

Employee Signature: _____ Date: _____

PART II - Employer Review and Recommendations

Human Resources Coordinator: _____ Date: _____

Recommend Approval: ( ) Yes ( ) No

(Rev. 02/10)