

FAMILY AND MEDICAL LEAVE (FMLA) APPLICATION AND PARENTAL LEAVE

As a TTUHSC GME Resident Physician, you are to apply for Family and Medical Leave (FMLA) coverage for FMLA Leave qualifying conditions/events requiring your absence from work. 30 days advance notice is requested when applying for FMLA/or Parental Leave. If 30 days advance notice is not possible, notice is to be provided as soon as practicable. Refer to HSC OP 70.32 Family and Medical Leave Act (FMLA Leave) for certification and additional information.

Section I: Employee Information		
Trainee's Full Name:	R #:	Department/Campus:
PGY:	Program Director:	Date of Notification:
Home Phone Number:	HSC Email Address:	Employee Home Mailing Address:
Section II: FMLA Information		
Note: Failure to Provide complete information may result in the delay and/or denial of FMLA Leave protection:		
Reason for FMLA Request: (Required)		
<input type="checkbox"/> Birth of a Child and/or care for the newborn child <input type="checkbox"/> Placement with the Employee of a child for Adoption/Foster care <input type="checkbox"/> Employee's Own Serious Health Condition <input type="checkbox"/> Employee's Spouse/Child/Parent who has a Serious Health Condition <input type="checkbox"/> Qualifying Military Exigency Leave for the Employee's Spouse/Child/Parent <input type="checkbox"/> Military Caregiver Leave for the Employee's Spouse/Child/Parent		
First Day of Absence: (Required)		
Period of Leave Request: (From (mm/dd/yyyy) and Through (mm/dd/yyyy) dates) (Required) through		

Click here to enter text.

If for the Birth of a Child, please provide the estimated due date:

If to care for Spouse/Child/Parent, please provide the name of the Spouse/Child/Parent and relationship:

If to care for a child, is the child under the age of 18?

- Yes
- No
- Unknown

Is this the result of an On The Job Injury? (Required)

- Yes
- No
- Unknown

Is your spouse employed by TTU/TTUHSC? (Required)

- Yes
- No
- Unknown

Have you taken FMLA in the past 12 months? (Required)

- Yes
- No
- Unknown

Are you filling this FMLA Application out because you received an Eligibility Letter requesting an application?

- Yes
- No

***Please provide Supporting Documentation and/or Certification of Health Care Provider**

[Certification of Health Care Provider for Employee's Serious Health Condition](#)

[Certification of Health Care Provider for Family Member's Serious Health Condition](#)

Section III: Attestation

I certify that I intend to return to the position listed above at the end of this leave.
Certification of Health Care Provider for Family Member's Serious Health Condition

Signature:

Date:

*** Please hand deliver completed form to the TTUHSC Graduate Medical Education Office. ***