

Paid Parental Leave Request Form & Agreement

EMPLOYEE INFORMATION

Employee Name: _____ Employee ID: _____ Rec #: _____
 FTE: _____ Hire Date: _____ Department: _____
 Department Rep Name: _____ Department Rep Email: _____
 Anticipated Birth or Placement for Adoption: _____ Anticipated Return to Work Date: _____
 Date of Anticipated Paid Parental Leave: From: _____ To: _____

Are there any provisions of the policy that deems the employee ineligible? Yes No

Will another FSU employee be taking Paid Parental leave for this birth? Yes No If yes, provide name: _____

Does the employee agree to the repayment provisions if the return to work requirements are not met? Yes No

Is the employee funded off a Contract & Grant? Yes No

If C&G funded, provide the project number(s) and their end dates:

By signing below, I understand that I must return to the University for a minimum of six (6) months and physically work 600 hours following participation in the program. Not fulfilling this commitment will result in my repayment of the portion of the parental leave used in excess of my leave balances. I also understand that if I have not been approved for FMLA (Family Medical Leave Act) by the Office of Human Resources, I must provide supporting documentation certifying the birth or adoption placement before the conclusion of program participation.

Employee Signature: _____ Date: _____

APPROVAL

Supervisor Name: _____ Signature: _____ Date: _____

Dean/Director Name: _____ Signature: _____ Date: _____