The University of Texas at Austin
Human Resources

Request for Parental Leave and Certification of Healthcare Provider

Section I - For Completion by the Employee: This form must be completed and returned to HR within 15 calendar days. Failure to return the form and any supporting documentation may result in the delay or denial of your Parental Leave request. Once this form and all supporting documentation is received, your request for Parental Leave will be reviewed and you will be notified via email whether your request is approved or denied.

UT Austin Employee's Name:	**Employee's EID:**	**Date:**
Employee's Address: (Number, Street, City, State, Zip)	**Employee's Home Phone:**	**Employee's Department:**
I Request Parental Leave for the Following Reason: ☐ **Birth of a Child –** Leave for the birth of my child. ☐ **Adoption or Foster Care Placement –** Leave for the adoption or placement of a child under three years of age.	**Expected Date of Birth, Adoption, or Placement:**	**Age of Child (if for Adoption or Foster):**

If your request for Parental Leave is due to the birth of a child, a healthcare provider must complete Section III below. If your request for Parental Leave (PL) is for the adoption or placement of a child under three years of age, then you must submit acceptable proof of placement or adoption such as a letter from a legitimate placement agency, or court order of adoption.

If your request is approved as PL, you will have the following **responsibilities** while on PL:

- You will be responsible for continuing to make your share of the premium payments on your health insurance to maintain benefits while you are on leave.
- You will be required to use your available paid sick (when applicable), vacation, compensatory, and/or other paid time off during your PL absence. This means that you will receive your paid time off, and the time off will also be considered protected PL and counted against your PL entitlement. If you do not meet the requirements for taking paid time off, you remain entitled to take unpaid PL.

If your request is approved as PL, you will have the following **rights** while on PL:

- You have a right under the Parental Leave Act for up to 12 weeks of unpaid leave that begins with the date of birth, adoption, or placement for foster care.
- You have the right to continue your participation in the University's health insurance programs. The University will continue to contribute its share of your health insurance premiums during any months in which you are using paid time off. The University will discontinue contributing its share of your premiums during any months in which you are on unpaid time off (formerly known as leave without pay or LWOP).
- You must be reinstated to the same or an equivalent job with the same pay, benefits, and terms and conditions of employment on your return from PL. If your leave extends beyond the end of your PL entitlement, you do not have return rights under PL.
- If you become eligible for leave under the Family and Medical Leave Act (FMLA) during your PL, then you will be placed on FMLA for the remainder of your leave, and all PL taken will be applied toward your 12 week FMLA entitlement.

I certify that the information listed above is true and complete, and that I have read and understand my rights and responsibilities while on Parental Leave.

X_____ _____
Employee PRINTED Name and Signature **Date**

Section II - For Completion by Patient: I authorize my licensed practitioner to release the completed Request for Parental Leave and Certification of Healthcare Provider form to the administrators of the Parental Leave Act at The University of Texas at Austin.

X_____ _____
Patient PRINTED Name and Signature **Date**

Section III - For Completion by the Health Care Provider : The **Genetic Information Nondiscrimination Act of 2008 (GINA)** prohibits employers and other entities covered by GINA Title II from requesting or requiring genetic information of an individual or family member of the individual, except as specifically allowed by this law. To comply with this law, we are asking that you not provide any genetic information when responding to this request for medical information. "Genetic Information" as defined by GINA includes an individual's family medical history, the results of an individual's or family member's genetic tests, the fact that an individual or an individual's family member sought or received genetic services, and genetic information of a fetus carried by an individual or an individual's family member or an embryo lawfully held by an individual or family member receiving assistive reproductive services.

Patient Name:	**Relationship to Employee:**	**Is Condition Pregnancy?** ☐ Yes ☐ No	**Expected Delivery Date:**	**Estimated Return to Work Date:**

X_____ _____
Health Care Provider Signature **Health Care Provider Printed Name**

_____ _____
Date **Phone**

_____
Type of Practice / Medical Specialty

SUBMIT FORM TO:
HR - Benefits & Leave
Secure eFax: (512) 471-7008

NEED HELP?
HRSC
Phone: (512) 471-4772