

**STATE OF TENNESSEE**  
**Application for Family or Medical Leave**  
**Family and Medical Leave Act of 1993**

Name: \_\_\_\_\_ Department: \_\_\_\_\_

Current Address: \_\_\_\_\_

Start Date of Anticipated Leave: \_\_\_\_\_

Expected Date of Return to Work: \_\_\_\_\_

Reason for Leave (Explain): \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**NOTE:** A leave request based on an employee's serious health condition or the serious health condition of an employee's spouse, child or parent must be accompanied by a verifying medical certification from a physician.

I hereby authorize the \_\_\_\_\_ (State agency) to contact my physician to verify the reason for my requested leave or for any other information concerning my requested family and medical leave.

I understand that a failure to return to work at the end of my leave period may be treated as a resignation unless an extension has been agreed upon and approved in writing by the \_\_\_\_\_ (State agency).

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**APPROVED BY:**

\_\_\_\_\_  
Supervisor

\_\_\_\_\_  
Division Manager

\_\_\_\_\_  
Personnel Officer

\_\_\_\_\_  
Appointing Authority