Request for Paid Leave
Medical Maternity & Parental Leave

Employees are expected to give at least one week's notice of the need for leave whenever possible. If emergency circumstances prevent the employee from giving one week's notice, the employee is expected to give as much notice as possible. Family Medical Leave (FMLA) will run concurrently with the leaves of absence listed on this form. Completed forms need to be sent to employeebenefits@byuh.edu.

Employee Information		
Name of Employee (last, first, middle)	Employee ID #	
Department	Date	
Estimate date is leave to begin	Estimated date of return	Original date of hire

Reason for Leave	
Medical Maternity Leave- 6 calendar weeks	Delivery date
Parental Leave- 5 consecutive work days	Birth date or Adoption date

Benefits participation during leave

All insurance premiums and other standard deductions will continue to be deducted from employee's pre-tax earnings.

Acknowledgement Signatures

I acknowledge that I have notified my supervisor and the Human Resource (HR) Department representative of my leave of absence for the reason noted above. I understand that no work is to be performed during this period. If changes occur that affect my leave. I understand that it is my responsibility to notify my supervisor and the HR department of those changes.

Employee Signature	Date
Supervisor Signature	Date
HR Signature	Date

Office Use Only

FMLA Eligible ☐ Yes ☐ No	FMLA hours available	Leave hours entered in WD	Initials of reviewer
Eligible for other state or local programs		Program	