



Application for Parental Leave – Part 1. Request

Graduate assistants requesting parental leave must complete this form at least four weeks prior to the anticipated start date of the leave. For more information, refer to "Parental Leave for Graduate Assistants" at funding.graduate.ucf.edu.

Send the completed form to the College of Graduate Studies at gradassistantship@ucf.edu or Fax to 407-823-6442.

Graduate Assistant

Name: \_\_\_\_\_ UCFID: \_\_\_\_\_

Knight's Email Address: \_\_\_\_\_ Phone Number: \_\_\_\_\_

Academic Program/Subplan: \_\_\_\_\_

Request for Parental Leave:

Estimated Date of Birth or Adoption: \_\_\_\_\_

Anticipated Start Date for Parental Leave: \_\_\_\_\_

Anticipated Return Date from Parental Leave: \_\_\_\_\_

If the other parent is a graduate assistant at UCF, please provide this information:

Name: \_\_\_\_\_ UCFID: \_\_\_\_\_

Academic Program/Subplan: \_\_\_\_\_

If this leave request is approved, I understand that:

- I will retain my student status and registration during the leave, as well as all privileges of an enrolled student.
I am responsible for conferring with my course instructors to develop plans as necessary to make up the academic work missed during my leave.
The paid leave is for up to six weeks but may be a shorter period, depending on my graduate assistantship agreement(s). My assistantship status will be maintained during the leave, including paid tuition remission and health insurance (if I accepted this coverage offered by the College of Graduate Studies).

Attachment to this form: Please attach your course schedule for the semester(s) of the leave request.

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

## Academic Program Approval

Academic Program Approval indicates that all faculty who are involved with the student's graduate study have been informed and will work with the student to develop and complete plans as necessary to make up the academic work missed during the parental leave.

If this leave request is approved, the College of Graduate Studies will pay the assistantship stipend equal to the rate of the existing assistantship agreement(s) during the approved leave period. Arrangements for this payment will be coordinated with the contact person provided below.

If you wish, you may hire a replacement at your own expense to fill the duties of the student on leave. This hire may be done using a short-term OPSGRD or a Supplemental Assignment for an existing graduate assistant. The Supplemental Assignment will be approved by the College of Graduate Studies as long as the replacement is in good academic standing with at least a Graduate Status GPA of 3.00 and has a history of academic progress in the degree program.

**Agreement ID(s) for all active assistantship agreements for this student during the anticipated leave period:** \_\_\_\_\_

**Hiring Department** - Provide the contact person to process ePAF(s) for funding account changes:

**Name:** \_\_\_\_\_

**Email:** \_\_\_\_\_

**Phone:** \_\_\_\_\_

**Approval Signatures:** Individuals listed below will receive notice via email of the leave request decision.

**Faculty Advisor:** \_\_\_\_\_ **Email Address:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Program Director:** \_\_\_\_\_ **Email Address:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Chair of Department:** \_\_\_\_\_ **Email Address:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Phone Number:** \_\_\_\_\_

**College of Graduate Studies:**

Approved     Denied

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

Dr. John Weishampel, Associate Dean, College of Graduate Studies

Comments:

## Application for Parental Leave – Part 2. Anticipated Parent Information

Fill in your name and UCFID below.

Have your health care provider or adoption agency confirm the details below and sign the form.

Send the completed form to the College of Graduate Studies at gradassistantship@ucf.edu or Fax 407-823-6442.

Name: \_\_\_\_\_ UCFID: \_\_\_\_\_

### Anticipated Parent Information

I confirm that the above named person is pregnant and the anticipated due date is: \_\_\_\_\_

I confirm that the above named person's parental partner is pregnant and the anticipated due date is: \_\_\_\_\_

I confirm that the above named person is awaiting adoption of an infant.

The anticipated date of adoption is: \_\_\_\_\_

The anticipated date of the infant's arrival is: \_\_\_\_\_

Comments:

### Health Care Provider

Print Name of Health Care Provider: \_\_\_\_\_

Signature of Health Care Provider: \_\_\_\_\_ Date: \_\_\_\_\_

Type of Practice: \_\_\_\_\_

License Number Issued by Florida Board of Examiners: \_\_\_\_\_

Health Care Provider's Address: \_\_\_\_\_

Health Care Provider's Telephone Number: \_\_\_\_\_

### Adoption Agency

Print Name of Adoption Agency: \_\_\_\_\_

Signature of Adoption Agency Official: \_\_\_\_\_ Date: \_\_\_\_\_

Adoption Agency's Address: \_\_\_\_\_

Adoption Agency's Telephone Number: \_\_\_\_\_