UNIVERSITY of SOUTH FLORIDA

Paid Parental Leave for Faculty Request Form

Section 1 – Completed by Faculty Member and Submit to Direct Supervisor or Academic Chair

Last name _____ First name _____

GEMS employee ID# _____ Title/rank _____

Department name _____ College/division _____

Employment type: ☐ 12 month faculty ☐ 9 month faculty Date of hire _____ FTE _____

Phone # _____ Email address _____ Mail point _____

Note Instructional Faculty leave period must conform to the dates of the academic semester. Non-instructional Faculty leave period must not exceed 3 months.

Instructional Faculty

Semester of anticipated leave: Choose one

Typical teaching load (number of courses assigned during the regular academic year semesters)_____

Non-Instructional Faculty or Clinical Faculty

Anticipated dates of leave: from _____ to _____

I have read and understand the Paid Parental Leave for Faculty Program Guidelines that include, but are not limited to, the following terms:

- Upon separation from employment or upon transfer between an annual leave and a non-annual leave accruing appointment, prior to leave payout, hours utilized for paid parental leave will be deducted.
- As a condition of participation, I acknowledge that there is an expectation that I will return to university employment for a minimum of one (1) academic year for faculty members with instructional responsibilities or for a minimum of one (1) calendar year for faculty members without instructional responsibilities.
- Failure to comply with the terms set forward in this signed agreement shall result in the requirement of repayment of salary received during the paid parental leave.
- By participating in this benefit program, my tenure clock is to be suspended.
  With extension, I will now be considered for tenure in Fall: Choose one
  ☐ Check here if you wish to opt out of this default clock suspension.

My signature below indicates my agreement with, and understanding of, the terms of the program.

Faculty member's signature _____ Date _____

Section 2 – Completed by department and submit to college dean (as appropriate)

Department contact _____ Phone # _____

Chair/director/supervisor name (printed) _____

Chair/director/supervisor signature* _____ Date _____

**If the tenure clock is being extended, I verify the date entered for consideration is correct.*

FOR USF HEALTH FACULTY: Eligibility Verification: ☐ At Least .75 FTE ☐ 1 Year Paid Faculty Service

Section 3 – Completed by the college dean (as appropriate) and submit to appropriate VP area

Dean name (printed) _____

Dean signature _____ Date _____

Section 4 – Completed by the VP area

VP/designee name (printed) _____

VP/designee's signature _____ Date _____

Send this completed form to:

Office of the Provost and Executive Vice President
Attention: Faculty Affairs
rlopez@usf.edu
For questions or assistance: (813) 974-2154

USF Health Faculty and Academic Affairs
Attention: Olga Joanow
ojoanow@usf.edu
For questions or assistance: (813) 974-1352