**Request for paid Supplemental Parental Leave (SPL) hours**

The Board of Regents Policy 3.3.13 on Parental Leave stipulates a regular employee holding Faculty, Administrative, Manager/Professional, Office/Service, or a Post-doctoral appointment are eligible to receive up to a total of eight (8) workweeks of paid leave for: 1) Care of a Newborn 2) Period of Incapacity, Prenatal Care, or Serious Health Condition Related to Childbearing 3) Care for a Birth Parent 4) Adoption. T*o review the policy in full:* [*Regent Policy 3.3.13*](https://nebraska.edu/-/media/unca/docs/offices-and-policies/policies/board-governing-documents/board-of-regents-policies.pdf)

Complete this form for paid Supplemental Parental Leave (SPL) hours only if all sick leave will have been exhausted before/during your leave. Contact your campus/Business Center Human Resources with questions or if you need assistance in completing this form.

Name (Employee Requesting SPL Hours): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

NUID or Personnel #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

Supervisor name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Anticipated Parental Leave Timeframe: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Anticipated SPL Start Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Anticipated End Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Total Number of anticipated SPL hours requested: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

🞏 This time will be taken as consecutive days off.

🞏 This time will be taken as intermittent leave. Specify the schedule below (dates/days/hours):

***Please note:*** *Intermittent leave is only available for reasons 1 and 3. If intermittent leave is approved, the employee must complete the leave within six (6) months following the child’s birth or relevant event.*

Qualifying Reason (select one)

I am requesting paid leave for the following reason:

❏ 1) Care of a Newborn (*foster parents are not eligible for leave*)  
❏ 2) Period of Incapacity, Prenatal Care, or Serious Health Condition Related to Childbearing

❏ 3) Care for Birth Parent

❏ 4) Adoption

Employee Certification

I certify that the information provided above is true and accurate. I understand that all available sick leave must be utilized prior to being eligible for paid leave under this policy. I understand that submission of this form does not guarantee approval, and that Human Resources may request additional documentation to process this request. [NOTE: additional documentation is submitted to HR not the immediate supervisor]

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

Employee Signature Date

Approval Signatures

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

Immediate Supervisor *Faculty Requests:* Dean/Director

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Human Resources/Vice Chancellor, as applicable