UNIVERSITY OF MARYLAND SYSTEM/UNIVERSITY OF BALTIMORE
REQUEST FOR FAMILY AND MEDICAL LEAVE

PART I: EMPLOYEE INFORMATION

1. Name:
Social Security Number:

2. Title:
Department:

3. Reason for requesting leave:

- ☐ a. Birth of a child
- ☐ b. Placement of a child for adoption/foster care.
- ☐ c. Care for a child within a 12 month period from birth or placement.
- ☐ d. Care for child, spouse, parent, or legal dependent with a serious health condition (be sure to answer #4 and #5).
- ☐ e. Serious health condition which makes me unable to perform the functions of my position.
- ☐ f. Call to Active Duty of qualifying family member in the Armed Forces
- ☐ g. Caregiver Leave for an Injured Service member

4. If 3d is checked, please indicate: ☐ Child ☐ Parent ☐ Spouse ☐ Legal Dependent

5. Name and Address of Family Member: _____

_____

6. Effective Date of Leave Request:

7. Date of anticipated return to work:

8. Are you requesting leave on an intermittent or reduced work schedule?

☐ **Yes*** ☐ **No**

***If yes, please provide a certification from a health care provider justifying the necessity for intermittent leave. On a separate sheet give a schedule of when you anticipate you will be unavailable for work.

9. I agree to take F&M Leave under the following paid and unpaid leave allocations:

☐ Period of Paid Leave FROM_____TO_____TOTAL NO. OF HOURS_____

☐ Period of Unpaid Leave FROM_____TO_____TOTAL NO. OF HOURS_____

Employees seeking leave because of Reasons 3a, 3c, 3d, or 3e *must* have a health care provider complete the Certification of Physician/Practitioner and return it to the Office of Human Resources within **7** days. Leave may be delayed until this is provided. Employees seeking to return to work after a leave because of Reason 3e, ***also*** must complete the Return to Work Medical Certification Form before they will be allowed to resume work. Employees may not be permitted to resume any position until a completed Return to Work Medical Certification Form is provided.

EMPLOYEE AGREEMENT

I hereby agree that while I am on leave, I will continue to pay my share of health insurance premiums, unless I elect to discontinue such coverage. Should I elect to discontinue coverage, I further understand that I will not be eligible to re-enroll without proof that I have been enrolled in another benefits plan during the period of the leave. I will, however be able to enroll in benefits during the next open enrollment. I also agree that if I fail to return to work at the end of the leave period, I will reimburse my agency for the cost of health benefits provided during my leave, unless I fail to return to work because of the continuation, recurrence, or onset of a serious health condition or because of other circumstances beyond my control. If I am unable to return to work because of a serious health condition, I will provide medical certification from the appropriate health care provider stating that I am unable to perform the functions of my position on the date that my leave expired, or that I am needed to care for a covered relative because he/she has a serious health condition on the date that my leave expired. I understand that while on FMLA leave, I will contact the Benefits Specialist after I have been on leave for 30 calendar days and at the end of each 30-day period afterwards.

Signed:_____ **Date:** _____

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PART II: TO BE COMPLETED BY THE EMPLOYING UNIT

The F&M Leave request has been reviewed with the employee. The employee will be restored to the same of equivalent position upon the conclusion of the leave. In the event that the employee's continued absence will result in substantial and grevious economic injury to the unit, the employee will be given notice as provided for in the BOR Policy on Family and Medical Leave.

Signature: _____ Date: _____
Supervisor

Signature: _____ Date: _____
Department Head

PART III: TO BE COMPLETED BY THE OFFICE OF HUMAN RESOURCES

Employees on leave must contact the Office of Human Resources after having been on leave for 30 calendar days and at the end of each 30-day period afterwards regarding their status and intention to return to work. This portion of the form is to be used by the Office of Human Resources to keep track of the periodic reports by the employee.

SCHEDULE OF EMPLOYEE PERIODIC REPORTS DURING LEAVE

DATE OF PERIODIC REPORT	STATUS OF HEALTH CONDITION	DATE OF ANTICIPATED RETURN TO WORK	PERIODIC REPORT CONDUCTED BY

REMARKS:

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