UNIVERSITY HUMAN RESOURCES

Staff Family Medical Leave Request

Part I – To be completed by employee											
Name:										**Date of Hire:**	**FTE %** 0%
Department:											
Title:											
UID:											

Have you worked at least 12 months with the University System or State of MD?	☐ Yes	☐ No	
Did your total hours worked in the past 12 months equal or exceed 1,040 hours?	☐ Yes	☐ No	
Total hours/day of paid or unpaid FML leave taken in the past 12 months:			

Reason for Leave (check all that apply)

A ☐	Birth of my child	**B** ☐	Placement of a child with me for adoption or foster care
C ☐	To care for my child within the 12 month period from birth or placement	**D** ☐	To care for my immediate family member with a serious health condition
E ☐	My own serious health condition	**F** ☐	To care for a covered service member's serious illness or injury
G ☐	Qualifying exigency		

If choosing D, F, or G please state the relationship of the family member to you:

Leave Period

Date Leave Commences:	Return to Work Date:	Total days requested:

Are you requesting intermittent leave or a reduced work schedule?	☐ Yes	☐ No
If yes, when will you be unavailable to work?		

Accrued/Paid Leave Balances (hours)

Annual Leave:	Sick Leave:
Personal Leave:	Compensatory Leave:

IMPORTANT – PLEASE READ CAREFULLY BEFORE SIGNING

1. I understand that if I am seeking leave for the birth of a child, placement of a child for adoption or foster care, or care of a child within a 12-month period after birth or placement, I must provide reasonable documentation or a statement of family relationship for purposes of confirming the relationship consistent with Section XIII of the Policy on Family and Medical Leave (FML) for Staff.
2. I understand that If I am seeking leave for my own or my immediate family member's serious health condition, I must provide a complete and sufficient Certification of Health Care Provider form consistent with Section XII of the Policy on FML for Staff. I also understand that I must provide reasonable documentation or a statement of family relationship if I am seeking leave for the care of my immediate family member.
3. I understand that I shall have 15 calendar days to obtain and submit a complete and sufficient Certification of Health Care Provider form, unless it is not practicable to do so despite diligent good faith efforts. I also understand that my leave may be delayed or denied if I fail to provide this information in a timely manner.
4. I understand that the University may require reasonable recertification as FML leave continues consistent with Section XII.4 of the Policy on FML for Staff.
5. I understand that if I am seeking to return to work after leave due to my own serious health condition, I must submit a Return to Work Certification prior to my return. I also understand that I may not be permitted to return to work/resume my position until I provide the certification.
6. I understand that if my FML period is unpaid, I am required to pay my share of premium payments in the manner required by the State of Maryland Department of Budget and Management unless I elect to discontinue such coverage consistent with Section IX.B.2 of the Policy on FML for Staff.
7. I also understand that the University shall recover its share of health premiums paid during a period of unpaid FML if I fail to return to work e.g. do not work for at least 30 calendar days, after FML is exhausted or eligibility expires. The only exception to this requirement is if I am unable to return due to the continuation, recurrence, or onset of my own serious health condition or my immediate family member or service member's serious health condition; or other circumstances beyond my control consistent with Section IX.C of the Policy on FML for Staff.
8. I understand that if I give notice that I will not be returning to work e.g. I resign, I will not be eligible to continue participating in employer health benefit plans except to the extent I am eligible as a retiree or under COBRA consistent with Section IX.B of the Policy on FML for Staff.
9. I understand that during my FML leave, I will be required to use my accrued paid leave appropriate to the purpose of the leave.

Part II – Signatures		
Employee		
Signature	**Print Name**	**Date**
Manager		
Signature	**Print Name**	**Date**
Department Head / Chair		
Signature	**Print Name**	**Date**