UNIVERSITY HUMAN RESOURCES

Request for Family Medical Leave

Part I – To be completed by employee												
Name:											Date university employment began	FTE %
Department:												
UID:												
Title:												
Have you worked at last 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 full and/or partial days of FML leave (paid or unpaid) taken in the past 12 months:												
Specify Reason for Leave												

A ☐	Birth of my child	**B** ☐	Placement of a child with me for adoption or foster care
C ☐	To care for my child within a 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:		
Dates Requested for Leave:		
Beginning Date:	Return Date:	Total # days:
Are you requesting intermittent leave or a reduced work schedule? ☐ Yes ☐ No		
If yes, when will you be unavailable to work?		

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IMPORTANT – READ CAREFULLY BEFORE SIGNING

If I am seeking leave because of reason B or C, I understand that I must provide appropriate legal documentation to support the request consistent with Section XII of the USM Policy on Family and Medical Leave. If I am seeking leave because of reason A, D, E, F, or G, I understand that I must provide a completed certification consistent with policy. I agree to return the appropriate documentation consistent with the specific reason for leave within 15 days, or as soon as practicable and I understand that my leave may be delayed or denied until I provide acceptable documentation. I understand that the University may require further medical certification during the course of my leave, as deemed appropriate. I agree that I will provide accurate and timely information related to my initial request for leave, request for continuation of my leave, and/or my return to work.

If I am seeking to return to work after leave due to my own serious health condition (reason E), I understand that I must provide certification of my fitness for duty to return to work and that I may not be permitted to return to work until acceptable certification is provided.

I agree that while I am on unpaid leave I will continue to pay my share of premium payments unless I elect to discontinue coverage. I understand that if I give notice that I will not be returning to work, I will not be eligible to continue participating in employer health benefit plans except to the extent that I am eligible as a retiree or under COBRA. The only exception to this requirement is if my failure to return is due to the continuation, recurrence, or onset of my own serious health condition or that of my immediate family member or covered service member. I also understand that the University shall recover its share of health premiums paid during a period of unpaid FML leave if I fail to return to work (does not work for at least 30 calendar days) after FML has been exhausted or my eligibility expires.

Part II – Signatures

Employee

Signature	Printed Name	Date

Manager

Signature	Printed Name	Date

Department Head / Chair

Signature	Printed Name	Date

Retain a copy of the request for your records and forward a copy of the completed request to the University Human Resources, Office of Staff Relations – 3110 Chesapeake Building.