REQUEST FOR FAMILY AND MEDICAL LEAVE (FML)
UNIVERSITY OF MARYLAND AT COLLEGE PARK

Part 1: TO BE COMPLETED BY EMPLOYEE

1. Name of Employee: _____
2. University ID Number: _____
3. Unit _____
4. Have you worked at least 12 months with the University and/or State?
   Yes ☐ No ☐
5. Do you estimate your total hours worked in the past 12 months equal or exceed 1040 hours? Yes ☐ No ☐
6. Position Title: _____
7. Total days previous FML (paid and unpaid) taken within the calendar year to date (include full and partial days)___ _____
8. Amount of available FML (60 days minus amount in #7): _____
9. Reason for requested leave (check one)
   a. (☐) birth of a child
   b. (☐) placement of a child for adoption or formal foster care
   c. (☐) care for a child within 12 month period from birth or formal adoption placement
   d. (☐) care for an immediate family member who has a serious health condition (children must be under age 18 unless otherwise disabled)
   e. (☐) my own serious health condition
   f. (☐) care of an employee's child under the age of 14 during a school vacation

If choosing d or f., please state relationship of family member to you _____

10. Date on which you wish to commence leave: _____
11. Date of anticipated return to work: _____
12. Total days of FML being requested: _____
13. Are you requesting leave on an intermittent or reduced leave schedule?
    Yes _☐__ No_☐__
14. If yes, please give schedule of when you will be unavailable for work. Attach separate sheet.

Note: Medical Documentation will be required for all illness-related leave.

IMPORTANT – READ CAREFULLY BEFORE SIGNING

If I am seeking leave because of reason 9.b. above I understand that I must provide appropriate legal documentation to support the request, consistent with the Policy on Family and Medical Leave. If I am seeking leave because of reason 9.d. or 9.e. above, I understand that I must provide a medical certification, consistent with the Policy on Family and Medical Leave, from the appropriate health care provider. I agree to return the appropriate documentation consistent with the specific reason, within 15 days, or as soon as practicable. I understand that my leave may be delayed until I provide this documentation or certification and that it may be denied if I fail to provide this information. I understand the University may require further medical certification during the course of the leave, as deemed appropriate. I agree that I will provide accurate and timely information related to my initial request for leave and to a request for continuation of, and return from leave.

If I am seeking to return to work after a leave due to my own serious illness (reason 9.e.), I must also provide certification of my fitness to return to work. I understand that I may not be permitted to resume my position until I provide certification.

I agree that while I am on unpaid leave and if I have elected to continue my health insurance coverage, I will continue to pay my share of premiums, unless I elect to discontinue such coverage.

I also agree that if I fail to return to work at the end of an unpaid leave or fail to stay in my position far at least 30 calendar days following completion of the leave, I shall reimburse the University for the health insurance premiums provided during my leave. The only exception to this requirement is if my failure to return or stay is because of continuation of the FML related reason.

I understand that the University will apply my accrued leave to my time off work for Family Medical Leave.

PART III: SIGNATURES

Employee_____ Date _____
(**Signature)** (**Please Print)**

Supervisor_____ Date _____
(**Signature)** (**Please Print**)

Dept. Head/Chair _____ Date _____
(**Signature)** (**Please Print**)

FRS Account Number to which Health Insurance is to be charged_____

Retain one copy for you departmental records. Forward one copy to the Staff Relations Office, University Human Resources, 3100 Chesapeake Building.

To guarantee continuation of health insurance coverage during an unpaid FML, you must contact the Employee Benefits Office, University Human Resources, at extension 5-5654. You must also copy this form to the Employee Benefits Office, University Human Resources, 1101 Chesapeake Building.

Rev 9/16