CONFIDENTIAL

FACULTY FAMILY MEDICAL LEAVE REQUEST

University of Maryland, College Park

Name:	**UID:**
Title:	**Department:**
Date of Hire:	**FTE%:** 0%
Eligibility	
Have you been employed for at least 12 months as a USM or State of MD employee? ◯ **Yes** ◯ **No**	
Was your FTE ≥ 50% during the 12-month period immediately preceding the start of your leave under a 9-month or longer contract? ◯ **Yes** ◯ **No**	
Have you worked at least 1,040 hours as a USM or State of MD employee during the 12-month period immediately preceding the start of your leave? ◯ **Yes** ◯ **No**	
Total hours/days of paid or unpaid FML leave taken in the past 12 months:	
Reason for Leave (check all that apply)	
☐ Birth of my child ☐ Placement of a child with me for adoption or foster care ☐ Care of my child during the 12-month period immediately following birth or placement	☐ My own serious health condition ☐ Care of my immediate family member with a serious health condition ☐ Qualifying exigency ☐ Care for a covered service member's serious illness or injury
If caring for an immediate family member, covered service member, or taking qualifying exigency leave, what is your relationship to them:	
If caring for your child, state the child's age:	

Leave Period		
Date leave commences:	Return to work date:	Total days requested:
Are you requesting ◯ intermittent leave or a ◯ reduced work schedule?		
For intermittent or reduced schedule, when you will be unavailable to work?		

Accrued/Paid Leave Balances (hours)	
Annual Leave:	Personal Leave:
Creditable Sick Leave:	Non-Creditable/Collegial Sick Leave:

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 Faculty.
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 Faculty. 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 Faculty.
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 Faculty.
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 Faculty.
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 Faculty.
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.
10. I agree to make written arrangements with my Chair about duties to be assigned to me upon my return to the University. A letter detailing these arrangements should be attached to this application.

SIGNATURES

Faculty Member	Print Name	Date
Manager	Print Name	Date
Department Chair	Print Name	Date
Dean	Print Name	Date