UNIVERSITY of MARYLAND BALTIMORE

FAMILY AND MEDICAL LEAVE
Request Form – Family Member

☐ **Original Request** ☐ **Extension** ☐ **Recertification**

Completed forms must be submitted to:

University of Maryland; Attn: Human Resource Services; ER/LR
620 West Lexington Street, 3rd Floor; Baltimore, MD 21201
Phone: 410-706-7302 | Fax: 410-706-0169
E-mail: leaveforms@umaryland.edu

PART I: TO BE COMPLETED BY EMPLOYEE	
Name:	Employee ID#:
Home Address:	
Date of which employment with university began:	Number of years as a USM and/or State employee:
Department:	Job Title:
Supervisor's Name:	Payroll Representative's Name:
Is this request due to a work-related injury? ☐Yes ☐No	
Has FMLA been previously granted by the University in the last 12 months? ☐Yes ☐No	
Request for: ☐Continuous FML ☐Intermittent FML ☐Reduced Schedule FML	
Leave to begin on:	Expected return to work date:

Reason for requested leave:

a. ☐Birth of a child
b. ☐Placement of a child for adoption or foster care (Please include documentation)
c. ☐Care for a child within initial 12-month period following birth or placement for adoption/foster care (*)
d. ☐Care for an immediate (eligible) family member who has a serious health condition (**)
e. ☐Due to a qualifying exigency of a spouse, child, or parent on active duty or called to active-duty status in support of a contingency operation as a member of the National Guard or Reserves.

(*) If you selected "c" above, and this is to be intermittent leave involving a modified work schedule, please provide details regarding when you expect to be working. **NOTE:** Please be advised that all request for a modified work schedule must be reviewed and approved by the employee's Supervisor and/or Department Head.

Schedule: (Please attach a separate sheet if necessary): _____
_____
_____

(**) If you selected "d" above, please indicate the name and relationship of the family member (ie: spouse, parent, child, etc.):

Name:_____ Relationship:_____

The Family and Medical Leave Act (FMLA) permits an employer to require that you, (the employee), submit timely, complete, and sufficient medical certification to support a request for FMLA leave. FMLA leave is used for your own serious health condition or that of an eligible family member. When requested by your employer, you are required to obtain (or retain) the benefit of FMLA protections. You must return this form within 15 calendar days, or as soon as practicable. All medical certifications from physicians and eligible medical practitioners are reviewed solely by the employee and the appropriate personnel within the University. These reviews are for the purpose of evaluation to approve family and medical leave requests. Employees seeking to return to work after approved FMLA for their own serious health condition must provide certification from their healthcare provider stating that they have been cleared to return to work. Employees may not be permitted to return to work until the certification of their fitness to return has been provided. If the employee's serious health condition prevents them from being able to return to work as originally expected, the employee must provide medical certification indicating that they have not been cleared to return. This certification should be provided on or before the date that their approved FMLA leave expires. Certification from a healthcare provider is also required if the employee is unable to return to work when originally expected due to the serious health condition of an eligible family member. As above, this should be provided on or before the date that the approve FMLA leave expires.

Please Note: If the employee was on Accident Leave or Parental Leave in the prior 12 months of this request, or during this FMLA period then Accident Leave or Parental Leave will be counted towards the available FMLA hours, if qualifying.

Employee Signature:	Phone:	Date:

Certification of Health Care Provider for Family Member's Serious Health Condition under the Family and Medical Leave Act

U.S. Department of Labor
Wage and Hour Division

WAGE AND HOUR DIVISION

DO NOT SEND COMPLETED FORM TO THE DEPARTMENT OF LABOR. RETURN TO THE PATIENT.

OMB Control Number: 1235-0003
Expires: 6/30/2026

The Family and Medical Leave Act (FMLA) provides that an employer may require an employee seeking FMLA leave to care for a family member with a serious health condition to submit a medical certification issued by the family member's health care provider. 29 U.S.C. §§ 2613, 2614(c)(3); 29 C.F.R. § 825.305. The employer must give the employee **at least 15 calendar days** to provide the certification. If the employee fails to provide complete and sufficient medical certification, his or her FMLA leave request may be denied. 29 C.F.R. § 825.313. Information about the FMLA may be found on the WHD website at www.dol.gov/agencies/whd/fmla.

SECTION I - EMPLOYER

Either the employee or the employer may complete Section I. While use of this form is optional, this form asks the health care provider for the information necessary for a complete and sufficient medical certification, which is set out at 29 C.F.R. § 825.306. **You may not ask the employee to provide more information than allowed under the FMLA regulations, 29 C.F.R. §§ 825.306-825.308.** Additionally, you **may not** request a certification for FMLA leave to bond with a healthy newborn child or a child placed for adoption or foster care.

Employers must generally maintain records and documents relating to medical information, medical certifications, recertifications, or medical histories of employees or employees' family members created for FMLA purposes as confidential medical records in separate files/records from the usual personnel files and in accordance with 29 C.F.R. § 1630.14(c)(1), if the Americans with Disabilities Act applies, and in accordance with 29 C.F.R. § 1635.9, if the Genetic Information Nondiscrimination Act applies.

(1) Employee name: _____
First Middle Last

(2) Employer name: _____ Date: _____ (mm/dd/yyyy)
(List date certification requested)

(3) The medical certification must be returned by _____ (mm/dd/yyyy)
(Must allow at least 15 calendar days from the date requested, unless it is not feasible despite the employee's diligent, good faith efforts.)

SECTION II - EMPLOYEE

Please complete and sign Section II before providing this form to your family member or your family member's health care provider. The FMLA allows an employer to require that you submit a timely, complete, and sufficient medical certification to support a request for FMLA leave due to the serious health condition of your family member. If requested by your employer, your response is required to obtain or retain the benefit of the FMLA protections. 29 U.S.C. §§ 2613, 2614(c)(3). **You are responsible for making sure the medical certification is provided to your employer within the time frame requested, which must be at least 15 calendar days.** 29 C.F.R. §§ 825.305-825.306. Failure to provide a complete and sufficient medical certification may result in a denial of your FMLA leave request. 29 C.F.R. § 825.313.

(1) Name of the family member for whom you will provide care: _____

(2) Select the relationship of the family member to you. The family member is your:

☐ Spouse ☐ Parent ☐ Child, under age 18

☐ Child, age 18 or older and incapable of self-care because of a mental or physical disability

Spouse means a husband or wife as defined or recognized in the state where the individual was married, including in a common law marriage or same-sex marriage. The terms "child" and "parent" include in loco parentis relationships in which a person assumes the obligations of a parent to a child. An employee may take FMLA leave to care for an individual who assumed the obligations of a parent to the employee when the employee was a child. An employee may also take FMLA leave to care for a child for whom the employee has assumed the obligations of a parent. No legal or biological relationship is necessary.

Employee Name: _____

(3) Briefly describe the care you will provide to your family member: (**Check all that apply**)

☐ Assistance with basic medical, hygienic, nutritional, or safety needs ☐ Transportation

☐ Physical Care ☐ Psychological Comfort ☐ Other: _____

(4) Give your **best estimate** of the amount of leave needed to provide the care described:

_____

(5) If a **reduced work schedule** is necessary to provide the care described, give your **best estimate** of the reduced schedule you are able to work. From _____ (mm/dd/yyyy) to _____ (mm/dd/yyyy), I am able to work _____ (hours per day) _____ (days per week)

Employee Signature _____ **Date** _____ (mm/dd/yyyy)

SECTION III - HEALTH CARE PROVIDER

Please provide your contact information, complete all relevant parts of this Section, and sign the form below. A family member of your patient has requested leave under the FMLA to care for your patient. The FMLA allows an employer to require that the employee submit a timely, complete, and sufficient medical certification to support a request for FMLA leave to care for a family member with a serious health condition. For FMLA purposes, a "serious health condition" means an illness, injury, impairment, or physical or mental condition that involves inpatient care or continuing treatment by a health care provider. For more information about the definitions of a serious health condition under the FMLA, see the chart at the end of the form.

You also may, but are **not required** to, provide other appropriate medical facts including symptoms, diagnosis, or any regimen of continuing treatment such as the use of specialized equipment. Please note that some state or local laws may not allow disclosure of private medical information about the patient's serious health condition, such as providing the diagnosis and/or course of treatment.

Health Care Provider's name: (Print) _____

Health Care Provider's business address: _____

Type of practice / Medical specialty: _____

Telephone: _____ Fax: _____ E-mail: _____

PART A: Medical Information

Limit your response to the medical condition for which the employee is seeking FMLA leave. Your answers should be your **best estimate** based upon your medical knowledge, experience, and examination of the patient. **After completing Part A, complete Part B to provide information about the amount of leave needed.** Note: For FMLA purposes, "incapacity" means the inability to work, attend school, or perform regular daily activities due to the condition, treatment of the condition, or recovery from the condition. Do not provide information about genetic tests, as defined in 29 C.F.R. § 1635.3(f), genetic services, as defined in 29 C.F.R. § 1635.3(e), or the manifestation of disease or disorder in the employee's family members, 29 C.F.R. § 1635.3(b).

(1) Patient's Name: _____

(2) State the approximate date the condition started or will start: _____ (mm/dd/yyyy)

(3) Provide your **best estimate** of how long the condition lasted or will last: _____

(4) For FMLA to apply, care of the patient must be medically necessary. Briefly describe the type of care needed by the patient (e.g., assistance with basic medical, hygienic, nutritional, safety, transportation needs, physical care, or psychological comfort).

_____

Employee Name: _____

(5) Check the box(es) for the questions below, as applicable. For all box(es) checked, the amount of leave needed must be provided in Part B.

☐ **Inpatient Care**: The patient (☐ has been / ☐ is expected to be) admitted for an overnight stay in a hospital, hospice, or residential medical care facility on the following date(s): _____

☐ **Incapacity plus Treatment**: (e.g. outpatient surgery, strep throat)

Due to the condition, the patient (☐ has been / ☐ is expected to be) incapacitated for more than three consecutive, full calendar days from: _____ (mm/dd/yyyy) to _____ (mm/dd/yyyy).

The patient (☐ was / ☐ will be) seen on the following date(s): _____

_____

The condition (☐ has / ☐ has not) also resulted in a course of continuing treatment under the supervision of a health care provider (e.g. prescription medication (other than over-the-counter) or therapy requiring special equipment)

☐ **Pregnancy**: The condition is pregnancy. List the expected delivery date: _____ (mm/dd/yyyy).

☐ **Chronic Conditions**: (e.g. asthma, migraine headaches) Due to the condition, it is medically necessary for the patient to have treatment visits at least twice per year.

☐ **Permanent or Long Term Conditions**: (e.g. Alzheimer's, terminal stages of cancer) Due to the condition, incapacity is permanent or long term and requires the continuing supervision of a health care provider (even if active treatment is not being provided).

☐ **Conditions requiring Multiple Treatments**: (e.g. chemotherapy treatments, restorative surgery) Due to the condition, it is medically necessary for the patient to receive multiple treatments.

☐ **None of the above**: If none of the above condition(s) were checked, (i.e., inpatient care, pregnancy) no additional information is needed. Go to page 4 to sign and date the form.

(6) If needed, briefly describe other appropriate medical facts related to the condition(s) for which the employee seeks FMLA leave. (e.g., use of nebulizer, dialysis)

_____

PART B: Amount of Leave Needed

For the medical condition(s) checked in Part A, complete all that apply. Several questions seek a response as to the frequency or duration of a condition, treatment, etc. Your answer should be your **best estimate** based upon your medical knowledge, experience, and examination of the patient. Be as specific as you can; terms such as "lifetime," "unknown," or "indeterminate" may not be sufficient to determine if the benefits and protections of the FMLA apply.

(7) Due to the condition, the patient (☐ had / ☐ will have) **planned medical treatment(s)** (scheduled medical visits) (e.g. psychotherapy, prenatal appointments) on the following date(s): _____

_____

(8) Due to the condition, the patient (☐ was / ☐ will be) **referred to other health care provider(s)** for evaluation or treatment(s).

State the nature of such treatments: (e.g. cardiologist, physical therapy) _____

Provide your **best estimate** of the beginning date _____ (mm/dd/yyyy) and end date _____ (mm/dd/yyyy). for the treatment(s).

Provide your **best estimate** of the duration of the treatment(s), including any period(s) of recovery (e.g. 3 days/week)

_____

Employee Name: _____

(9) Due to the condition, the patient (☐ was / ☐ will be) **incapacitated for a continuous period of time**, including any time for treatment(s) and/or recovery.

Provide your **best estimate** of the beginning date _____ (mm/dd/yyyy) and end date _____ (mm/dd/yyyy). for the period of incapacity.

(10) Due to the condition, it (☐ was / ☐ is / ☐ will be) medically necessary for the employee to be absent from work to provide care for the patient on an **intermittent basis** (periodically), including for any episodes of incapacity i.e., episodic flare-ups. Provide your **best estimate** of how often (frequency) and how long (duration) the episodes of incapacity will likely last.

Over the next 6 months, episodes of incapacity are estimated to occur _____ times per (☐ day ☐ week ☐ month) and are likely to last approximately _____ (☐ hours ☐ days) per episode.

Signature of Health Care Provider _____ Date: _____ (mm/dd/yyyy)

Definitions of a Serious Health Condition (See 29 C.F.R. §§ 825.113-.115)
Inpatient Care
• An overnight stay in a hospital, hospice, or residential medical care facility. • Inpatient care includes any period of incapacity or any subsequent treatment in connection with the overnight stay.
Continuing Treatment by a Health Care Provider (any one or more of the following)
Incapacity Plus Treatment: A period of incapacity of more than three consecutive, full calendar days, and any subsequent treatment or period of incapacity relating to the same condition, that also involves either: o Two or more in-person visits to a health care provider for treatment within 30 days of the first day of incapacity unless extenuating circumstances exist. The first visit must be within seven days of the first day of incapacity; or, o At least one in-person visit to a health care provider for treatment within seven days of the first day of incapacity, which results in a regimen of continuing treatment under the supervision of the health care provider. For example, the health provider might prescribe a course of prescription medication or therapy requiring special equipment.
Pregnancy: Any period of incapacity due to pregnancy or for prenatal care.
Chronic Conditions: Any period of incapacity due to or treatment for a chronic serious health condition, such as diabetes, asthma, migraine headaches. A chronic serious health condition is one which requires visits to a health care provider (or nurse supervised by the provider) at least twice a year and recurs over an extended period of time. A chronic condition may cause episodic rather than a continuing period of incapacity.
Permanent or Long-term Conditions: A period of incapacity which is permanent or long-term due to a condition for which treatment may not be effective, but which requires the continuing supervision of a health care provider, such as Alzheimer's disease or the terminal stages of cancer.
Conditions Requiring Multiple Treatments: Restorative surgery after an accident or other injury; or, a condition that would likely result in a period of incapacity of more than three consecutive, full calendar days if the patient did not receive the treatment.

PAPERWORK REDUCTION ACT NOTICE AND PUBLIC BURDEN STATEMENT

If submitted, it is mandatory for employers to retain a copy of this disclosure in their records for three years. 29 U.S.C. § 2616; 29 C.F.R. § 825.500. Persons are not required to respond to this collection of information unless it displays a currently valid OMB control number. The Department of Labor estimates that it will take an average of 15 minutes for respondents to complete this collection of information, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. If you have any comments regarding this burden estimate or any other aspect of this collection information, including suggestions for reducing this burden, send them to the Administrator, Wage and Hour Division, U.S. Department of Labor, Room S-3502, 200 Constitution Avenue, N.W., Washington, D.C. 20210.

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Employee Rights under the Family and Medical Act (FMLA) of 1993

The Family and Medical Leave Act (FMLA) require the University to provide up to 12 weeks (480 hours) of leave to eligible employees. To be eligible, University System of Maryland (USM) requires that an employee have worked for USM or State of Maryland for at least 12 months and have worked at least 1,040 hours in the 12 months preceding the leave. FMLA also includes a special leave entitlement that permits eligible employees to take up to 26 weeks of leave to care for a covered service member.

QUALIFYING REASONS FOR FMLA LEAVE

FMLA leave may be granted for **any** of the following reasons:

- The birth of a child, or placement of a child for adoption or foster care
- For a serious health condition that renders an employee temporarily unable to perform his/her job
- To care for the employee's spouse, child, or parent who has a serious health condition
- Due to a qualifying exigency of a spouse, child, or parent on active duty or called to active-duty status in support of a contingency operation as a member of the National Guard or Reserves
- For a serious injury or illness of a service member who is a spouse, child, parent, or next of kin

ADMINISTRATION:

The 12 weeks of FMLA leave may be paid, unpaid, or partially paid. **The University System of Maryland requires employees to use all accrued leave before going into an unpaid status;** therefore, any leave taken for a qualifying reason under FMLA is applied towards accrued leave balances. The University administers FMLA on a rolling 12-month period measured backward from the date an employee uses any FMLA. Leave can be taken continuously, intermittently or via a reduced schedule when medically necessary. Employees must make reasonable efforts to schedule leave for medical treatment so as not to unduly disrupt departmental operations. Applicable forms to apply for FMLA may be obtained online at https://www.umaryland.edu/hrs/forms/employee-and-labor-relations-forms/

EMPLOYEE RESPONSIBILITY:

FMLA is subject to meeting the requirements below:

- Provide 30 days advance notice in writing to direct supervisor when the leave is scheduled and foreseeable or as soon as practical in an emergency situation, to include anticipated duration
- Submit FMLA Application to HRS/ELR within 30 days when leave is scheduled and foreseeable or as soon as possible
- Provide medical certification completed by a physician to support a serious health condition of the employee or that of an immediate family member within 15 calendar days from the date of request
- Provide periodic updates to the direct supervisor, communicating the ability to return to work as indicated, providing additional medical certification to ER/LR if required
- Submit recertification every 30 days for conditions requiring intermittent leave
- Obtain leave balances to determine if sufficient pay is available, if not inquire about supplemental pay options
- Submit return to work certification from physician to your supervisor on your first day back to work

EMPLOYER RESPONSIBILITY:

- Inform employee of eligibility under FMLA within 5 days of the employee's request
- Inform employee of rights and responsibilities
- Maintain the employee's health coverage under any group plan for the duration of FMLA designated leave
- Inform employee of leave designated as FMLA-protected and the amount counted against leave entitlement
- Restore employee to his/her original or equivalent position with equivalent pay and benefits upon return from FML
- Ensure the use of FMLA does not result in the loss of any employment benefit that accrued prior to the start of an employee's leave

FOR FURTHER INFORMATION:

USM POLICY #VII - 7.50 USM POLICY ON FAMILY AND MEDICAL LEAVE FOR EXEMPT AND NONEXEMPT STAFF EMPLOYEES can be found at: http://www.usmd.edu/regents/bylaws/SectionVII/VII750.pdf

UMB Policy #VII - 7.50(A) UMB POLICY ON FAMILY AND MEDICAL LEAVE FOR EXEMPT AND NONEXEMPT STAFF EMPLOYEES can be found at: http://www.umaryland.edu/policies-and-procedures/library/human-resources/policies/vii-750a.php

Please contact Employee and Labor Relations at 410-706-7302 with any questions.