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UMBC
AN HONORS UNIVERSITY IN MARYLAND

Department of Human Resources
University of Maryland, Baltimore County
1000 Hilltop Circle
Administration Building, 5th Floor
Baltimore, Maryland 21250

GENERAL INFORMATION: 410-455-2337
FAX: 410-455-1064
VOICE/TTY: 410-455-3233
www.umbc.edu

CONFIDENTIAL

REQUEST FOR FAMILY AND MEDICAL LEAVE ACT (FMLA)

The Family and Medical Leave Act (FMLA) Policy is in Section VII.7.50 of the UMBC Policies website (www.umbc.edu/policies).

Part I : TO BE COMPLETED BY EMPLOYEE

Type of FMLA Request (check one): ☐ Initial Request ☐ Recertification ☐ New Request (Previous FMLA period expired)

1. Name:	**4.** Supervisor Name:
2. Department:	**5.** Employment Date:
3. Position Title:	**6.** Total F&M Leave taken within the past 12 months: ☐ hours ☐ days

7. Reason for requested leave *(check all that apply):*

- ☐ **a.** Birth of a child
- ☐ **b.** Placement of a child for adoption or foster care
- ☐ **c.** Care for a child within a 12 month period from birth or placement
- ☐ **d.** Care for an immediate family member who has a serious health condition
- ☐ **e.** My own serious health condition

If you selected "d", please state the name, relationship and address of the family member:

Name: Relationship: Address:

8. Date on which you wish to commence leave:	**9.** Date of anticipated return to work:

10. Are you requesting leave on an intermittent or reduced leave schedule? Yes ☐ No ☐

11. If you answered "Yes" to #10, please specify a schedule of when you will be available for work. **NOTE:** Please be advised that the request for a modified work schedule must be reviewed and approved by the employee's Supervisor and/or Department Head as well as the Department of Human Resources.

Schedule (Please attach a separate sheet if necessary):

Employees seeking leave because of reason indicated on number 7d and 7e above must complete the attached medical certificate form and return it within 30 days, or as soon as practicable. I understand that my leave may be delayed until I provide a completed medical certification form. I understand that UMBC may require further medical certification during the course of the leave, as deemed appropriate, for treatment that is scheduled during work hours for serious medical conditions and that I will provide accurate and timely information related to a request for continuation of modification(s) to and return from leave.

Employees seeking to return to work after a leave because of their own serious illness (Reason 7e) also must provide certification of their fitness to return to work. I understand that I may not be permitted to resume my position with UMBC, until I provide certification of my fitness to return to work.

In accordance with the HIPPA law, all medical certifications from physicians and practitioners are reviewed solely by the employee and the appropriate personnel staff of the Human Resources Department for the purpose of evaluating and approving family and medical leave requests.

I hereby agree that while I am on leave, I will continue to pay my share of health insurance premiums. I understand that if I do not pay my health insurance premiums my health insurance will be discontinued. I also agree that if I fail to return to work at the end of the leave period, I will reimburse UMBC for the payments made by UMBC for my health benefits during my leave, unless I elect to discontinue such coverage. I also agree that if I fail to return to work at the end of the leave period. I will reimburse UMBC for the cost of health benefits provided during my leave, unless I fail to return to work because of the continuation, recurrence or onset of a serious health condition or because of other circumstances beyond my control. If I am unable to return to work because of serious health conditions, I will provide medical certification from the date that my leave expired, or that I am needed to care for a covered relation because he/she has a serious health condition on the date that my leave expired.

Signature of Employee:	Date:

Part II: TO BE COMPLETED BY EMPLOYING UNIT

The F&M leave request has been reviewed with employee. The employee will be restored to the same or equivalent position upon the conclusion of the leave.

Restoration of Key Employees: In the event that the employee's continued absence will result in substantial and grievous economic injury to the unit, the employee will be given notice as provided in the BOR policy on Family and Medical Leave.

Supervisor's Remarks:

Signature of Supervisor: Date:

Department Head's Remarks:

Signature of Department Head: Date:

Copies of the request for leave, certification forms and any modifications to them during the period of leave shall be forwarded to UMBC's Department of Human Resources to become part of the employee's official Family and Medical Leave file.

Physicians Portion can be Faxed directly to Human Resources at: 410-455-1064

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Certification of Physician or Practitioner
Family and Medical Leave Act (FMLA)

Part I: TO BE COMPLETED BY PHYSICIAN OR PRACTITIONER

1. Employee's name:

2. Patient's name *(if other than employee)*:

2a. Relationship to employee:

3. The last page of this packet describes what is meant by a **"serious health condition"** under the Family and Medical Leave Act. Does the patient's condition[1] qualify under any of the categories described? If so, please check the applicable category.

- ☐ **a.** Hospital Care
- ☐ **b.** Absence Plus Treatment
- ☐ **c.** Pregnancy
- ☐ **d.** Chronic Conditions Requiring Treatments
- ☐ **e.** Permanent/Long-Term Conditions Requiring Supervision
- ☐ **f.** Multiple Treatments (Non-Chronic Conditions)

4. Please describe the diagnosis and medical facts which support your certification, including a brief statement as to how the medical facts meet the criteria of one of the above categories:

5. **a.** State the approximate **date** the condition commenced, and the probable duration of the condition (and also the probable duration of the patient's present **incapacity**[2] if different):

b. Will it be necessary for the employee to take work only **intermittently or to work on a less than full schedule** as a result of the condition (including for treatment described in Item 6 below)? ☐ Yes ☐ No

If Yes, please provide the probable duration:

c. If the condition is a **chronic condition** (condition d) or **pregnancy**, state whether the patient is presently incapacited[2] and the likely duration and frequency of **episodes of incapacity**[2]:

[1] Here and elsewhere on this form, the information sought relates **only** to the condition for which the employee is taking FMLA leave.

[2] "Incapacity," for purposes of FMLA, is defined to mean inability to work, attend school or perform other regular daily activities due to the serious health condition, treatment therefore, or recovery therefrom.

6. **a.** If additional **treatments** will be required for the condition, please provide an estimate of the probable number of such treatments.

If the patient will be absent from work or other daily activities because of **treatment** on an **intermittent** or **part-time** basis, also provide an estimate of the probable number of and interval between such treatments, actual or estimated dates of treatment if known, and period required for recovery if any:

b. If any of these treatments will be provided by **another provider of health services** (e.g., physical therapist), please state the nature of the treatments:

c. **If a regimen of continuing treatment** by the patient is required under your supervision, please provide a general description of such regimen (e.g., prescription drugs, physical therapy requiring special equipment):

7. **a.** If medical leave is required for the employee's **absence from work** because of the **employee's own condition** (including absences due to pregnancy or a chronic condition), is the employee **unable to perform work** of any kind? ☐ Yes ☐ No

Further explanation (if needed):

b. If able to perform some work, is the employee **unable to perform any one or more of the essential functions of the employee's job** (the employee or the employer should supply you with information about the essential job functions)? ☐ Yes ☐ No

If Yes, please list the essential functions the employee is unable to perform:

c. If neither a. nor b. applies, is it necessary for the employee to be **absent from work for treatment**?
☐ Yes ☐ No

For certification relating to care for the employee's seriously-ill family member.

8. **a.** If leave is required to **care for a family member** of the employee with a serious health condition, **does the patient require assistance** for basic medical or personal needs or safety, or for transportation? ☐ Yes ☐ No

b. If no, would the employee's presence to provide **psychological comfort** be beneficial to the patient or assist in the patient's recovery? ☐ Yes ☐ No

c. If the patient will need care only **intermittently** or on a part-time basis, please indicate the probable **frequency** and **duration** of this need:

Name of Health Care Provider (please print):	Signature of Health Care Provider:	Type of Practice:
Address:		
Telephone Number:	Date:	

The physician or practitioner's certification may be returned to the employee or mailed to the following address for proper review and processing:

University of Maryland Baltimore County (UMBC)
Department of Human Resources
Attention: Mrs. Michele Kimery
Administration Building, Room 504
1000 Hilltop Circle
Baltimore, Maryland 21250

Part II: To be completed by the employee needing family leave to care for a family member:

State the care you will provide and an estimate of the period during which care will be provided, including a schedule if leave is to be taken intermittently or if it will be necessary for you to work less than a full schedule:

Employee Signature: Date:

A **"Serious Health Condition"** means an illness, injury impairment, or physical or mental condition that involves one of the following:

1. Hospital Care
   Inpatient care (i.e., an overnight stay) in a hospital, hospice, or residential medical care facility, including any period of incapacity[2] or subsequent treatment in connection with or consequent to such inpatient care.

2. Absence Plus Treatment
   (a) A period of incapacity[2] of **more than three consecutive calendar days** (including any subsequent treatment or period of incapacity[2] relating to the same condition), that also involves:

   (1) **Treatment**[3] **two or more times** by a health care provider, by a nurse or physician's assistant under direct supervision of a health care provider, or by a provider of a health care services (e.g., physical therapist)under orders of, or on referral by, a health care provider; or

   (2) **Treatment** by a health care provider on **at least one occasion** which results in a **regimen of continuing treatment**[4] under the supervision of the health care provider.

3. Pregnancy
   Any period of incapacity due to **pregnancy**, or for **prenatal care**.

4. Chronic Conditions Requiring Treatments
   A **chronic condition** which:

   (1) Requires **periodic visits** for treatment by a health care provider, or by a nurse or a physician's assistant under direct supervision of a health care provider;

   (2) Continues over an **extended period of time** (including recurring episodes of a single underlying condition); and

   (3) May cause **episodic** rather than a continuing period of incapacity[2] (e.g., asthma, diabetes, epilepsy, etc.).

5. Permanent/Long-term Conditions Requiring Supervision
   A period of **Incapacity**[2] which is **permanent or long-term** due to a condition for which treatment may not be effective. The employee or family member must be **under the continuing supervision of, but need not be receiving active treatment by, a health care provider**. Examples include Alzheimer's, a severe stroke, or the terminal stages of a disease.

6. Multiple Treatments (Non-Chronic Conditions)
   Any period of absence to receive **multiple treatments** (including any period of recovery therefrom) by a health care provider or by a provider of health care services under orders of, or on referral by, a health care provider, either for **restorative surgery** after an accident or other injury, **or** for a condition that **would likely result in a period of Incapacity**[2] **of more than three consecutive calendar days in the absence of medical intervention or treatment**, such as cancer (chemotherapy, radiation, etc.), severe arthritis (physical therapy), and kidney disease (dialysis).

[3]Treatment includes examinations to determine if a serious health condition exists and evaluations of the condition. Treatment does not include routine physical examinations, eye examinations, or dental examinations.

[4]A regimen of continuing treatment includes, for example, a course of prescription medication (e.g., an antibiotic) or therapy requiring special equipment to resolve or alleviate the health condition. A regimen of treatment does not include the taking of over-the-counter medications such as aspirin, antihistamines, or salves; or bed-rest, drinking fluids, exercise, and other similar activities that can be initiated without a visit to a health care provider.