Human Resources
Employee and Labor Relations
620 West Lexington Street
Baltimore, Maryland 21201
410 706 7302
410 706 0169 fax
www.umaryland.edu/hr

UNIVERSITY SYSTEM OF MARYLAND, BALTIMORE
FORM 1 – REQUEST FOR FAMILY AND MEDICAL LEAVE
Federal Family and Medical Leave (FMLA) and/or Maryland Paid Family and Medical Leave (PFML)
Email the completed form to: Leave_and_accom@umaryland.edu

INSTRUCTIONS
Use this form to request leave that may qualify under:

- The federal Family and Medical Leave Act (FMLA), and/or
- The Maryland Paid Family and Medical Leave (PFML) program applicable to eligible USM employees.
- Please include a completed certification form along with this request

Submission of this form does not automatically approve leave. A Designation Notice will be issued following review.

SECTION I – EMPLOYEE INFORMATION & PFML SELECTION

☐ **Opt In to PFML** – I would like to apply PFML to my eligible leave request. I understand that while applying PFML to my leave, my annual and sick leave will not accrue.

☐ **Opt Out of PFML** – I would like to use my accrued leave instead of PFML for my eligible leave request. I understand that while using my own accrued leave, my sick leave and annual leave will continue to accrue. I also understand that this leave will count toward my PFML leave entitlement for which I am eligible during the application year.

Employee Name: _____
UID / Employee ID: _____
Department: _____
Job Title: _____

Employee Category (check one):

☐ Faculty
☐ Exempt Staff
☐ Nonexempt Staff
☐ Contingent / Temporary
☐ Other: _____

Original Date of Hire (if known): _____
Supervisor Name: _____
Supervisor Email: _____
Preferred Contact Email: _____
Preferred Contact Phone: _____

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SECTION I.A – School of Medicine (SOM) FACULTY (Only complete this section if you are SOM faculty. If you are not SOM faculty, please proceed to Section II)

Do you hold a clinical faculty appointment in the School of Medicine (SOM)?

☐ *Yes, I am SOM clinical faculty (If yes, please review the following disclaimer and question)
☐ No, I am not SOM clinical faculty (If no, please proceed to Section II)

***Disclaimer for SOM clinical faculty:** If you selected "yes", please note that the maximum benefit amount available under the Maryland's Family and Medical Leave Insurance (FAMLI) Program is $1,000 per week, or $52,000 annually. Accordingly, the School of Medicine will use this pay rate for clinical faculty who do not use their accrued leave for PFML.

***Question for SOM Clinical Faculty:** Are you opting to receive the maximum benefit of $1,000 per week or will you use your accrued leave?

☐ I would like to receive the maximum benefit of $1,000 per week while on PFML. I understand that I may not apply accrued leave to supplement this pay during my time off.

☐ I would like to use my accrued leave while on PFML. I understand if my accrued leave exhausts while I am on PFML, I can request to receive the maximum benefit of $1,000 per week benefit for the remainder of my leave, or continue the remainder of my leave unpaid.

SECTION II – REASON FOR LEAVE

(Check all that apply)

☐ To care for a newborn child of the employee during the first year after the child's birth or because a child is being placed with the employee for adoption, foster care, or kinship care; or to bond with a child during the first year after birth or placement

☐ To care for a family member with a serious health condition

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☐ My own serious health condition
☐ Work-related injury
☐ Military caregiver leave (to care for a covered service member with a serious injury or illness)
☐ Qualifying exigency arising from a covered service member's active duty or call to active duty
☐ I am requesting leave related to military service (additional documentation required)

If caring for a family member or service member, indicate relationship:

☐ Child
☐ Parent
☐ Spouse
☐ Domestic Partner
☐ Grandparent
☐ Grandchild
☐ Sibling
☐ In loco parentis relationship
☐ Next of kin (military caregiver leave)

Other relationship (specify): _____

Military Leave Clarifications

A. Military Caregiver Leave (FMLA Only)

Military caregiver leave under FMLA may provide up to **26 workweeks of unpaid leave in a single 12-month period** to care for a covered service member with a serious illness or injury.

• This entitlement is available only under federal FMLA.
• PFML provides up to 12 weeks (or up to 24 weeks in limited circumstances) but does not extend to 26 weeks.
• If eligible for both, leave will run concurrently to the extent permitted by law. A Certification for Serious Injury or Illness of a Covered Service Member may be required.

B. Qualifying Exigency Leave (FMLA Only)

Qualifying exigency leave may be available under FMLA for certain urgent matters arising from the covered active duty of a spouse, child, or parent.

Examples may include:

• Short-notice deployment
• Military ceremonies or events
• Childcare arrangements

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• Financial or legal arrangements
• Rest and recuperation leave
Documentation supporting the exigency may be required.

SECTION III – LEAVE PERIOD REQUESTED

Anticipated Start Date of Leave: _____
Anticipated Return-to-Work Date (if known): _____
Is the leave request:

☐ Continuous (*Leave taken for one continuous, uninterrupted period of time)*
☐ Intermittent/Reduced schedule (*Leave taken in separate blocks of time or on a reduced work schedule rather than one continuous period*)

If intermittent or reduced schedule, estimate: Frequency (e.g., 2 times per month): _____
Duration per episode (hours or days):_____

Foreseeable Leave

If the need for leave is foreseeable (e.g., scheduled surgery, expected birth, planned treatment), indicate the date you first became aware of the need for leave:
Date aware: _____

SECTION IV – CERTIFICATION REQUIREMENTS

- Bonding leave (birth or placement) does not require medical certification; however, reasonable documentation of birth or placement may be required.
- Leave due to a serious health condition (your own or a family member's) requires completion of the appropriate Certification of Health Care Provider form.
- Military caregiver leave and qualifying exigency leave may require additional documentation.
- If certification is required, it must generally be returned within fifteen (15) calendar days unless not practicable despite diligent, good faith efforts.
- Failure to provide required certification may result in delay or denial of leave protection.

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SECTION V – IMPORTANT FMLA AND PFML INFORMATION

1. If eligible, FMLA and PFML leave will run concurrently to the extent permitted by law.
2. FMLA provides:
    a. Up to 12 workweeks in a rolling forward 12-month period.

Up to twenty-six (26) workweeks of FMLA leave in a single 12-month period measured forward from the date military caregiver leave begins.

1. PFML provides:
    a. Up to 12 weeks (480 hours) per PFML Application Year.
    b. In limited circumstances, PFML may provide up to 24 weeks (960 hours) in a single Application Year.
    c. The PFML Application Year begins on the Sunday of the calendar week in which PFML leave begins.
    d. Intermittent PFML may not be taken in increments of less than four (4) hours.
    e. PFML is paid at the employee's regular rate of pay and may not be conditioned upon exhaustion of accrued leave.
2. Both FMLA & PFML leave are job-protected. Upon return, the employee will generally be restored to the same or an equivalent position, subject to applicable legal exceptions.
3. The University prohibits interference with, restraint of, or retaliation against any employee for requesting or taking leave under FMLA or PFML. Employees who believe their rights have been violated may report concerns to their institution's Human Resources Office.

SECTION VIII – EMPLOYEE CERTIFICATION

I certify that the information provided on this form is accurate and complete to the best of my knowledge.
Employee Signature: _____
Date: _____

Send the completed form to:
Email: Leave_and_accom@umaryland.edu
Fax: 410-706-0169

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UNIVERSITY SYSTEM OF MARYLAND, BALTIMORE
Paid Family & Medical Leave - CERTIFICATION OF HEALTH CARE PROVIDER
Adapted from U.S. Department of Labor Wage & Hour Division – FORM WH-380-F

Family Member's Serious Health Condition

Confidential Medical Record – Maintain Separately from Personnel File

Return completed form to the employee.

This certification is used to evaluate whether the employee's family member's condition qualifies under the federal Family and Medical Leave Act (FMLA) and/or Maryland Paid Family and Medical Leave (PFML). Approval and designation of leave are determined separately by the employer. 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 this section.

The FMLA and PFML allow an employer to require an employee seeking leave to care for a family member with a serious health condition to submit a timely, complete, and sufficient medical certification issued by the family member's health care provider.

The employer must generally allow at least fifteen (15) calendar days for the employee to return this certification unless it is not practicable despite the employee's diligent, good faith efforts.

Employers must maintain medical certifications as confidential medical records in files separate from personnel records in accordance with applicable law.

Employee Name: _____

Employer Name: University System of Maryland

Date Certification Requested: _____

Certification Due Date (at least 15 calendar days): _____

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Family Member's Name: _____

Relationship to Employee (as represented by employee): _____

Employee Job Title: _____

Employee's Regular Work Schedule: _____

Clarification of Family Member Definition

For FMLA, "family member" includes a spouse, parent, or child as defined by federal law.
For Maryland PFML, "family member" may include additional relationships as defined by state law. Eligibility determinations are made by the employer.

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 and the Maryland PFML allow an employer to require that you submit a timely, complete, and sufficient medical certification to support a request for FMLA/PFML 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 FMLA/PFML protections. 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.

Failure to provide a complete and sufficient medical certification may result in a denial of your FMLA/PFML leave request.

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

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

☐Domestic Partner ☐Grandparent ☐Grandchild

☐Sibling ☐In loco parentis relationship

☐Other relationship (specify): _____

_____

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.

3. Briefly describe the care you will provide for 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)

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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/PFML 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

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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)*.
   _____

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

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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

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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)

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.

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HEALTH CARE PROVIDER CERTIFICATION

I certify that the information provided is true and complete to the best of my knowledge.

Health Care Provider Signature: _____

Printed Name: _____

License Number (if applicable): _____

State of Licensure: _____

Date: _____

Definitions of a Serious Health Condition (Adapted from 29 C.F.R. §§ 825.113–825.115)

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:

- 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,
- 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

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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.

Employee Rights under Policy on Paid Family and Medical Leave for USM Employees

Paid Family and Medical Leave (PFML) requires the University to provide up to 12 weeks (480 hours) of leave to eligible employees. PFML also includes a special leave entitlement that permits eligible employees to take up to 24 weeks of leave in the same Application Year when both parental leave and employee's own serious health condition occur in the same year, regardless of the order in which the leave is taken.

QUALIFYING REASONS FOR PFML LEAVE

PFML 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 or kinship.
- For a serious health condition that renders an employee temporarily unable to perform his/her job
- To care for the employee's family member
    - Child (of any age)
    - Parent, Stepparent or parent-in-law
    - Spouse or domestic partner
    - Grandparent or grandchild
    - Sibling
    - Other qualifying relationships defined by law
- Due to a qualifying exigency
    - Caring for a covered service member with a serious health condition resulting from military service when the employee is the service member's next of kin, or
    - Addressing a qualifying exigency related to a family member's military deployment.

ADMINISTRATION:

PFML is a paid benefit, therefore, you will continue to receive your regular rate of pay at your regular work schedule, excluding premium pay or shift differentials. This benefit is based on FTE; therefore, part-time employees will receive a proportional amount. Annual leave and Sick and Safe Leave will not accrue while an employee is on PFML. The University administers PFML on an Application Year. A PFML Application Year is a 12-month period that begins on the Sunday of the calendar week when your PFML starts. Leave can be taken continuously, intermittently or via a reduced schedule when medically necessary. Applicable forms to apply for PFML may be obtained online at https://www.umaryland.edu/hr/resources-and-support/forms/

EMPLOYEE RESPONSIBILITY:

PFML is subject to meeting the requirements below:

- Foreseeable – when the need for PFML is foreseeable, an employee shall provide at least 30 calendar days' notice, but not more than 60 calendar days' notice, in advance of when the leave is anticipated to begin.
- Unforeseeable – when an employee did not or could not have known about the need for PFML 30 calendar days before the commencement of leave, the employee shall be required to provide notice as soon as practicable. With good cause, a request for PFML may be submitted after the leave has begun but not later than 60 calendar days after the start date,
- Employees must make reasonable efforts to schedule leave for medical treatment so as not to unduly disrupt departmental operations.
- Submit PFML Request packet to HRELR Leave Management Department within 60 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 HRELR Leave Management Department if required
- Submit return to work certification from physician to HRELR Leave Management Department prior to or on your first day back to work

EMPLOYER RESPONSIBILITY:

- Inform employee of eligibility under PFML within 10 business 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 PFML designated leave

- Inform employee of leave designated as PFML-protected and the amount counted against leave entitlement
- Restore employee to their original or equivalent position with equivalent pay and benefits upon return from approved PFML
- Ensure the use of PFML 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 - 7.51 POLICY ON PAID FAMILY AND MEDICAL LEAVE FOR USM EMPLOYEES can be found at:
https://www.usmd.edu/regents/bylaws/SectionVII/VII-7.51.pdf

Please contact HR ELR Leave Management Department at 410-706-7302 with any questions.