

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

PART I: TO BE COMPLETED BY FACULTY MEMBER

1. Name of Faculty Member _____
2. Social Security Number _____
3. Department _____
4. Title _____
5. Have you been employed with the University at least 12 months? Yes No
6. Do you estimate your total hours worked in the past 12 months equal or exceed 1040 hours (equivalent to 6 months full-time)? Yes No
7. Total days FML (paid and unpaid) taken within the calendar year to date _____
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 in your care 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
 - e. my own serious health condition
 - f. care of my 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. Faculty member's current accrued paid leave*: Annual Leave _____ Personal Days _____ Creditable Sick Leave _____ Non-creditable/Collegial Sick Leave _____
14. Are you requesting leave on an intermittent or reduced leave schedule? Yes No
15. If yes, please attach a separate sheet giving a schedule of when you will be unavailable for work.

* The faculty member's accrued paid leave may be applied toward Family Medical Leave at either the faculty member's request or at the designation of the University.

PART II: CONDITIONS FOR IMPLEMENTATION
IMPORTANT – READ CAREFULLY BEFORE SIGNING

1. 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.
2. 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.
3. 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.
4. 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.
5. 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.
6. 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.
7. 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.
8. 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 for 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.
9. I understand that my accrued paid leave may be applied toward Family Medical Leave at either my request or at the designation of the University.

Faculty Member _____ Date _____

Supervisor _____ Date _____

Department Chair _____ Date _____

Dean _____ Date _____

Assoc. Provost for Faculty Affairs _____ Date _____

FRS account number to which health insurance is to be charged _____