ST MARY'S
COLLEGE of MARYLAND

Office of Human Resources
18952 East Fisher Road
St. Mary's City, MD, 20686

www.smcm.edu
TEL: 240-895-4309
FAX: 240-895-4997

REQUEST FOR FAMILY/MEDICAL LEAVE

EMPLOYEE INFORMATION

1. Name:______________________________Title/Dept:_________________________________

2. Mailing Address:____

3. Primary Phone: _________________________________

3. Reason for requesting leave:

   a. ☐ Birth of child
   b. ☐ Placement of a son or daughter for adoption/foster care.
   c. ☐ Care for child, spouse, parent, or legal dependent with a serious health condition

      (be sure to answer No. 4 and No. 5).

   d. ☐ Serious health condition which makes me unable to perform the functions of my position.
   e. ☐ Care for a military family member suffering from a serious injury or illness.
   f. ☐ My spouse, child or parent is a service member who is on active duty (or has been notified that he or she will be called to active duty in the near future)

4. If 3c, 3e or 3f, is checked, please indicate: ☐ Child ☐ Parent ☐ Spouse ☐ Legal Dependent

5. Name and Address of Family Member: ____

____

6. Efective Date of Leave Request:____

7. Date of anticipated return to work:____

8. Are you requesting leave on an intermittent or reduced work schedule? ☐ Yes* ☐ No *If yes, please provide certification from a health care provider justifying the necessity for intermittent leave.

Employees seeking leave due to reason 3c through 3f must have a health care provider complete a Certification of Health Care form and return it to the Office of Human Resources within 15 days, or as soon as practicable. Leave may be delayed until completed documentation is provided.

FAMILY MEDICAL LEAVE ACT (FMLA) EMPLOYEE AGREEMENT

I hereby agree that while I am on Family/Medical leave, I will continue to pay my share of health insurance premiums, 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 St. Mary's College 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 a serious health condition, I will provide medical certification from the appropriate health care provider stating that I am unable to perform the functions of my position on the date that my leave expired, or that I am needed to care for a covered relative because he/she has a serious health condition on the date that my leave expired. It is the policy of St. Mary's College to prohibit employees from working for another employer, in any capacity, while on FMLA.

Once you've completed and saved this form, please email your document to: hr@smcm.edu

Signed:____ Date:___________________