ST. MARY'S COLLEGE OF MARYLAND
REQUEST FOR FAMILY/MEDICAL LEAVE

EMPLOYEE INFORMATION

1. Name:_____

2. Title:_____ Dept:_____

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. Effective 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. I understand that while on Family/Medical leave, I will contact the Office of Human Resources at (240) 895-4309 on the first Monday of each month regarding my status and intention to return to work. It is the policy of St. Mary's College to prohibit employees from working for another employer, in any capacity, while on FMLA

Signed:_____ Date:_____

TO BE COMPLETED BY THE APPOINTING AUTHORITY

Employees on leave must contact the Office of Human Resources on the first Monday of each month regarding their status and intention to return to work. This portion of the form is to be used by the Office of Human Resources to keep track of the periodic reports by the employee.

SCHEDULE OF EMPLOYEE PERIODIC REPORTS DURING LEAVE

Date of Periodic Report	Status of Health Condition	Date of Anticipated Return to Work	Periodic Report Conducted By

REMARKS: