CONFIDENTIAL

BOWIE STATE UNIVERSITY
REQUEST FOR FAMILY & MEDICAL LEAVE

PART I. TO BE COMPLETED BY EMPLOYEE (Please type or print legibly.)

1. Name of employee (last, first, middle initial)
2. Employee ID Number
3. Position Title
4. Department
5. Total F & M Leave used within calendar year to date
6. Total F & M Leave Requested

7. Reason to request leave
   - a. ☐ Birth of a child or foster care
   - b. ☐ Placement of 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
   - f. ☐ The need to take care of a covered service member's serious injury or illness
   - g. ☐ Qualifying exigencies arising out of military active duty and call-up

If "d", "f" or "g", please state name, address and relation of immediate family member or service member.

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?
    - a. ☐ Yes
    - b. ☐ No
11. If "Yes", please give schedule of when you will be unavailable for work. (Attach separate sheet, if necessary.)

EMPLOYEE AGREEMENT

I hereby agree to comply with the BSU Implementation Procedures for the USM Policy on Family and Medical Leave. I understand that employees seeking leave for reason 7(a), 7(b) or 7(c) above must provide legal certification of the birth, adoption or foster care, and for reason 7(d), 7(e), 7(f) and 7(g) must complete a Certification of Physician or Practitioner Form. These certifications are to be attached to the request and submitted 30 days before the requested leave is scheduled to start or as soon as practical. I understand that my leave may be delayed until I provide the completed certifications. I understand that Bowie State University (BSU) may require further medical certification during the course of the leave as deemed appropriate and for treatment that is scheduled during work hours for serious medical conditions. I understand that I must provide accurate and timely information related to a request for continuation of, modification(s) to and return from leave.

I understand that employees seeking to return to work after a leave because of their own serious illness (reason 7e), must also provide certification of their fitness to return to work. I understand that I may not be permitted to resume my position with BSU until I provide certification of my fitness to return to work. I understand that my failure to return to work at the conclusion of my leave, without prior written notification, shall be interpreted as a resignation from BSU service.

I hereby agree that while I am on leave, I will continue to pay my share of health insurance premiums, unless I elect to discontinue such coverage. Should I elect to discontinue coverage, I further understand that I will not be eligible to re-enroll without proof that I have been enrolled in another benefits plan during the period of leave. I will, however, be able to enroll in benefits during the next open enrollment. I also agree that if I fail to return to work at the end of the leave period, I will reimburse BSU for the cost of health benefits provided by BSU 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 an immediate family member because he/she has a serious condition on the date that my leave expired.

Signature_____ Date_____

PART II. TO BE COMPLETED BY THE EMPLOYING UNIT

The F&M Leave request has been reviewed with the BSU employee. The employee may be restored to the same or equivalent position upon the conclusion of the leave. In the event that the employee's continued absence will result in substantial and grievous economic injury to the department, the employee will be given notice as provided for in the USM Policy on Family and Medical Leave and associated BSU implementation procedures.

Signature: _____ Date: _____
Supervisor/Department Head

Signature: _____ Date: _____
Vice President/Provost

Submit original request and certification forms to the Office of Human Resources for approval 30 days in advance of requested begin date of the leave. A copy of the request form will be returned to the department when leave is approved so that periodic reports may be conducted by the department as deemed appropriate. Copies of the request for leave, certification forms and any modifications to them during the period of leave must be forwarded to the Office of Human Resources to become part of the employee's official Family and Medical Leave file.

SCHEDULE OF PERIODIC REPORTS (This portion of the form is to be used by the Employing Unit to keep track of periodic reports by the employee when further reports are deemed appropriate.)

Date of Periodic Report	Status of Health Condition	Date of Anticipated Return to Work	Signature of Person Conducting Report

Supervisor's Remarks:

This request has been received and processed by the Office of Human Resources. The employee ☐ has been ☐ will be advised in writing of the terms and conditions of any F & M Leave granted.

Signature: _____ Date: _____
Senior Director of Human Resources

FAMILY AND MEDICAL LEAVE
DEFINITION OF A SERIOUS HEALTH CONDITION

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

1. Hospital Care

   In patient care (i.e., an overnight stay) in a hospital, hospice, or residential medical care facility, including any period of incapacity or subsequent treatment in connection with or consequent to such in patient care.

2. Absence Plus Treatment

   a) A period of incapacity of more than three consecutive days (including any subsequent treatment or period of incapacity 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 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:

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

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

   c) May cause episodic rather than a continuing period of incapacity (e.g., asthma, diabetes, epilepsy, etc.).

5. Permanent/Long-term Conditions Requiring Supervision

   A period of incapacity 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 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 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, kidney disease (dialysis).

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[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 regiment 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.

Certification of Health Care Provider for Family Member's Serious Health Condition (Family and Medical Leave Act)

U.S. Department of Labor
Wage and Hour Division

DO NOT SEND COMPLETED FORM TO THE DEPARTMENT OF LABOR; RETURN TO THE PATIENT.

OMB Control Number: 1235-0003
Expires: 8/31/2021

SECTION I: For Completion by the EMPLOYER

INSTRUCTIONS to the EMPLOYER: The Family and Medical Leave Act (FMLA) provides that an employer may require an employee seeking FMLA protections because of a need for leave to care for a covered family member with a serious health condition to submit a medical certification issued by the health care provider of the covered family member. Please complete Section I before giving this form to your employee. Your response is voluntary. While you are not required to use this form, you may not ask the employee to provide more information than allowed under the FMLA regulations, 29 C.F.R. §§ 825.306-825.308. Employers must generally maintain records and documents relating to medical certifications, recertifications, or medical histories of employees' family members, created for FMLA purposes as confidential medical records in separate files/records from the usual personnel files and in accordance with 29 C.F.R. § 1630.14(c)(1), if the Americans with Disabilities Act applies, and in accordance with 29 C.F.R. § 1635.9, if the Genetic Information Nondiscrimination Act applies.

Employer name and contact: _____

_____

SECTION II: For Completion by the EMPLOYEE

INSTRUCTIONS to the EMPLOYEE: Please complete Section II before giving this form to your family member or his/her medical provider. The FMLA permits an employer to require that you submit a timely, complete, and sufficient medical certification to support a request for FMLA leave to care for a covered family member with a serious health condition. If requested by your employer, your response is required to obtain or retain the benefit of FMLA protections. 29 U.S.C. §§ 2613, 2614(c)(3). Failure to provide a complete and sufficient medical certification may result in a denial of your FMLA request. 29 C.F.R. § 825.313. Your employer must give you at least 15 calendar days to return this form to your employer. 29 C.F.R. § 825.305.

Your name: _____
First Middle Last

Name of family member for whom you will provide care: _____
First Middle Last

Relationship of family member to you: _____

If family member is your son or daughter, date of birth: _____

Describe care you will provide to your family member and estimate leave needed to provide care:

_____

_____

_____

_____ _____
Employee Signature Date

CONTINUED ON NEXT PAGE

SECTION III: For Completion by the HEALTH CARE PROVIDER

INSTRUCTIONS to the HEALTH CARE PROVIDER: The employee listed above has requested leave under the FMLA to care for your patient. Answer, fully and completely, all applicable parts below. 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 as "lifetime," "unknown," or "indeterminate" may not be sufficient to determine FMLA coverage. Limit your responses to the condition for which the patient needs leave. Do not provide information about genetic tests, as defined in 29 C.F.R. § 1635.3(f), or genetic services, as defined in 29 C.F.R. § 1635.3(e). Page 3 provides space for additional information, should you need it. Please be sure to sign the form on the last page.

Provider's name and business address: _____

Type of practice / Medical specialty: _____

Telephone: (_____) _____ Fax:(_____) _____

PART A: MEDICAL FACTS

1. Approximate date condition commenced: _____

   Probable duration of condition: _____

   Was the patient admitted for an overnight stay in a hospital, hospice, or residential medical care facility?
   ___No ___Yes. If so, dates of admission: _____

   Date(s) you treated the patient for condition: _____

   Was medication, other than over-the-counter medication, prescribed? ___No ___Yes.

   Will the patient need to have treatment visits at least twice per year due to the condition? ___No ____ Yes

   Was the patient referred to other health care provider(s) for evaluation or treatment (e.g., physical therapist)?
   ____ No ____Yes. If so, state the nature of such treatments and expected duration of treatment:

   _____

   _____

2. Is the medical condition pregnancy? ___No ___Yes. If so, expected delivery date: _____

3. Describe other relevant medical facts, if any, related to the condition for which the patient needs care (such medical facts may include symptoms, diagnosis, or any regimen of continuing treatment such as the use of specialized equipment):

_____

_____

_____

_____

PART B: AMOUNT OF CARE NEEDED: When answering these questions, keep in mind that your patient's need for care by the employee seeking leave may include assistance with basic medical, hygienic, nutritional, safety or transportation needs, or the provision of physical or psychological care:

4. Will the patient be incapacitated for a single continuous period of time, including any time for treatment and recovery? ___No ___Yes.

   Estimate the beginning and ending dates for the period of incapacity: _____

   During this time, will the patient need care? __ No __ Yes.

   Explain the care needed by the patient and why such care is medically necessary:

   _____

   _____

   _____

   _____

   _____

5. Will the patient require follow-up treatments, including any time for recovery? ___No ___Yes.

   Estimate treatment schedule, if any, including the dates of any scheduled appointments and the time required for each appointment, including any recovery period:

   _____

   Explain the care needed by the patient, and why such care is medically necessary: _____

   _____

6. Will the patient require care on an intermittent or reduced schedule basis, including any time for recovery? __ No __ Yes.

   Estimate the hours the patient needs care on an intermittent basis, if any:

   _____ hour(s) per day; _____ days per week from _____ through _____

   Explain the care needed by the patient, and why such care is medically necessary:

   _____

   _____

   _____

   _____

CONTINUED ON NEXT PAGE

7. Will the condition cause episodic flare-ups periodically preventing the patient from participating in normal daily activities? ____No ____Yes.

   Based upon the patient's medical history and your knowledge of the medical condition, estimate the frequency of flare-ups and the duration of related incapacity that the patient may have over the next 6 months (e.g., 1 episode every 3 months lasting 1-2 days):

   Frequency: _____ times per _____ week(s) _____ month(s)

   Duration: _____ hours or ___ day(s) per episode

   Does the patient need care during these flare-ups? ____ No ____ Yes.

   Explain the care needed by the patient, and why such care is medically necessary: _____

_____

_____

_____

_____

ADDITIONAL INFORMATION: IDENTIFY QUESTION NUMBER WITH YOUR ADDITIONAL ANSWER.

_____

_____

_____

_____

_____

_____

_____ _____

Signature of Health Care Provider **Date**

PAPERWORK REDUCTION ACT NOTICE AND PUBLIC BURDEN STATEMENT

If submitted, it is mandatory for employers to retain a copy of this disclosure in their records for three years. 29 U.S.C. § 2616; 29 C.F.R. § 825.500. Persons are not required to respond to this collection of information unless it displays a currently valid OMB control number. The Department of Labor estimates that it will take an average of 20 minutes for respondents to complete this collection of information, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. If you have any comments regarding this burden estimate or any other aspect of this collection information, including suggestions for reducing this burden, send them to the Administrator, Wage and Hour Division, U.S. Department of Labor, Room S-3502, 200 Constitution Ave., NW, Washington, DC 20210.
DO NOT SEND COMPLETED FORM TO THE DEPARTMENT OF LABOR; RETURN TO THE PATIENT.