

**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. Social Security 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? | 11. If "Yes", please give schedule of when you will be unavailable for work. (Attach separate sheet, if necessary.) |
| a. <input type="checkbox"/> Yes                                            |                                                                                                                     |
| b. <input type="checkbox"/> No                                             |                                                                                                                     |

**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\_\_\_\_\_

**University System of Maryland**  
**CERTIFICATION OF HEALTH CARE PROVIDER**  
**(Family and Medical Leave Act of 1993)**

1. Employee's Name:
2. Patient's Name (if different from employee):
3. The attached sheet describes what is meant by "serious health condition" under the Family and Medical Leave Act. Does the patient's condition<sup>1</sup> qualify under any of the categories described? If so, please check the applicable category.  
  
(1) \_\_\_\_\_ (2) \_\_\_\_\_ (3) \_\_\_\_\_ (4) \_\_\_\_\_ (5) \_\_\_\_\_ (6) \_\_\_\_\_, or None of the above \_\_\_\_\_
4. Describe the medical facts, which support your certification, including a brief statement as to how the medical facts meet the criteria of one of these categories:
- 5a. State the approximate date the condition commenced, and the probable duration of the condition (and also the probable duration of the patient's present incapacity<sup>2</sup> if different):
- 5b. Will it be necessary for the employee to take work only intermittently or to work on a less than full schedule as a result of the condition (including for treatment described in item 6 below)? \_\_\_\_\_  
  
If yes, give the probable duration:
- 5c. If the condition is a chronic condition (condition #4) or pregnancy, state whether the patient is presently incapacitated and the likely duration and frequency of episodes of incapacity:
- 6a. If additional treatments will be required for the condition, provide an estimate of the probable number of such treatments.  
  
If the patient will be absent from work or other daily activities because of treatment on an intermittent or part-time basis, also provide an estimate of the probable number and interval between such treatments, actual or estimated dates of treatment if known, and period required for recovery if any.
- 6b. If any of these treatments will be provided by any other provider of health services (e.g., physical therapist), please state the nature of the treatments.
- 6c. If a regimen of continuing treatment by the patient is required under your supervision, provide a general description of such regimen (e.g., prescription drugs, physical therapy requiring special equipment):

<sup>1</sup>Here and elsewhere on this form, the information sought, relates only to the condition for which the employee is taking FMLA leave.

<sup>2</sup> "Incapacity," for the purposes of FMLA, is defined to mean inability to work, attend school or perform other regular daily activities due to the serious health condition, treatment therefore, or recovery therefrom.

- 7a. If medical leave is required for the employee's absence from work because of the employee's own condition (including absences due to pregnancy or a chronic condition), is the employee unable to perform work of any kind? \_\_\_\_\_
- 7b. If able to perform some work, is the employee unable to perform any one or more of the essential functions of the employee's job (the employee or the employer should supply you with information about the essential job functions)? \_\_\_\_\_. If yes, please list the essential functions the employee is unable to perform:
- 7c. If neither a. nor b. applies, is it necessary for the employee to be absent from work for treatment? \_\_\_\_\_
- 8a. If leave is required to care for a family member of the employee with a serious health condition, does the patient require assistance for basic medical or personal needs or safety, or for transportation? \_\_\_\_\_
- 8b. If no, would the employee's presence to provide psychological comfort be beneficial to the patient or assist in the patient's recovery? \_\_\_\_\_
- 8c. If the patient will need care only intermittently or on a part-time basis, please indicate the probable duration of this need:

...

\_\_\_\_\_  
(Signature of Health Care Provider)

\_\_\_\_\_  
(Type of Practice)

\_\_\_\_\_  
(Address)

\_\_\_\_\_  
(Telephone Number)

**To be completed by the employee needing family leave to care for a family member:**

State the care you will provide and an estimate of the period during which care will be provided, including a schedule if leave is to be taken intermittently or if it will be necessary for you to work less than full schedule:

\_\_\_\_\_  
(Employee signature)

\_\_\_\_\_  
(Date)

PART II. TO BE COMPLETED BY THE EMPLOYING UNIT

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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: \_\_\_\_\_  
Supervisor

Date: \_\_\_\_\_

Signature: \_\_\_\_\_  
Department Head

Date: \_\_\_\_\_

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.

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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 |
|-------------------------|----------------------------|------------------------------------|---------------------------------------|
|                         |                            |                                    |                                       |
|                         |                            |                                    |                                       |
|                         |                            |                                    |                                       |
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Supervisor's Remarks:

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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: \_\_\_\_\_  
Senior Director of Human Resources

Date: \_\_\_\_\_

## 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<sup>3</sup> 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<sup>4</sup> 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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<sup>3</sup>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.

<sup>4</sup>A regimen 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.