

**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. Position Title              |
| 3. Manager Name  | 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?<br>a. <input type="checkbox"/> Yes<br>b. <input type="checkbox"/> 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**

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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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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: \_\_\_\_\_  
                  Manager of Benefit and Wellness

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.

Certification of Health Care Provider for Family Member's Serious Health Condition under the 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: 6/30/2026

The Family and Medical Leave Act (FMLA) provides that an employer may require an employee seeking FMLA leave to care for a family member with a serious health condition to submit a medical certification issued by the family member's health care provider. 29 U.S.C. §§ 2613, 2614(c)(3); 29 C.F.R. § 825.305. The employer must give the employee at least 15 calendar days to provide the certification. If the employee fails to provide complete and sufficient medical certification, his or her FMLA leave request may be denied. 29 C.F.R. § 825.313. Information about the FMLA may be found on the WHD website at www.dol.gov/agencies/whd/fmla.

SECTION I - EMPLOYER

Either the employee or the employer may complete Section I. While use of this form is optional, this form asks the health care provider for the information necessary for a complete and sufficient medical certification, which is set out at 29 C.F.R. § 825.306. You may not ask the employee to provide more information than allowed under the FMLA regulations, 29 C.F.R. §§ 825.306-825.308. Additionally, you may not request a certification for FMLA leave to bond with a healthy newborn child or a child placed for adoption or foster care.

Employers must generally maintain records and documents relating to medical information, medical certifications, recertifications, or medical histories of employees or 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.

(1) Employee name: \_\_\_\_\_
First Middle Last

(2) Employer name: \_\_\_\_\_ Date: \_\_\_\_\_ (mm/dd/yyyy)
(List date certification requested)

(3) The medical certification must be returned by \_\_\_\_\_ (mm/dd/yyyy)
(Must allow at least 15 calendar days from the date requested, unless it is not feasible despite the employee's diligent, good faith efforts.)

SECTION II - EMPLOYEE

Please complete and sign Section II before providing this form to your family member or your family member's health care provider. The FMLA allows an employer to require that you submit a timely, complete, and sufficient medical certification to support a request for FMLA leave due to the serious health condition of your family member. If requested by your employer, your response is required to obtain or retain the benefit of the FMLA protections. 29 U.S.C. §§ 2613, 2614(c)(3). You are responsible for making sure the medical certification is provided to your employer within the time frame requested, which must be at least 15 calendar days. 29 C.F.R. §§ 825.305-825.306. Failure to provide a complete and sufficient medical certification may result in a denial of your FMLA leave request. 29 C.F.R. § 825.313.

(1) Name of the family member for whom you will provide care: \_\_\_\_\_

(2) Select the relationship of the family member to you. The family member is your:

- Spouse Parent Child, under age 18
Child, age 18 or older and incapable of self-care because of a mental or physical disability

Spouse means a husband or wife as defined or recognized in the state where the individual was married, including in a common law marriage or same-sex marriage. The terms "child" and "parent" include in loco parentis relationships in which a person assumes the obligations of a parent to a child. An employee may take FMLA leave to care for an individual who assumed the obligations of a parent to the employee when the employee was a child. An employee may also take FMLA leave to care for a child for whom the employee has assumed the obligations of a parent. No legal or biological relationship is necessary.

Employee Name: \_\_\_\_\_

(3) Briefly describe the care you will provide to your family member: **(Check all that apply)**

- Assistance with basic medical, hygienic, nutritional, or safety needs     Transportation  
 Physical Care     Psychological Comfort     Other: \_\_\_\_\_

(4) Give your **best estimate** of the amount of leave needed to provide the care described:

(5) If a **reduced work schedule** is necessary to provide the care described, give your **best estimate** of the reduced schedule you are able to work. From \_\_\_\_\_ (mm/dd/yyyy) to \_\_\_\_\_ (mm/dd/yyyy), I am able to work  
\_\_\_\_\_ (hours per day)    \_\_\_\_\_ (days per week)

Employee Signature \_\_\_\_\_ Date \_\_\_\_\_ (mm/dd/yyyy)

### SECTION III - HEALTH CARE PROVIDER

Please provide your contact information, complete all relevant parts of this Section, and sign the form below. A family member of your patient has requested leave under the FMLA to care for your patient. The FMLA allows an employer to require that the employee submit a timely, complete, and sufficient medical certification to support a request for FMLA leave to care for a family member with a serious health condition. For FMLA purposes, a "serious health condition" means an illness, injury, impairment, or physical or mental condition that involves inpatient care or continuing treatment by a health care provider. For more information about the definitions of a serious health condition under the FMLA, see the chart at the end of the form.

You also may, but are **not required** to, provide other appropriate medical facts including symptoms, diagnosis, or any regimen of continuing treatment such as the use of specialized equipment. Please note that some state or local laws may not allow disclosure of private medical information about the patient's serious health condition, such as providing the diagnosis and/or course of treatment.

Health Care Provider's name: (Print) \_\_\_\_\_

Health Care Provider's business address: \_\_\_\_\_

Type of practice / Medical specialty: \_\_\_\_\_

Telephone: \_\_\_\_\_ Fax: \_\_\_\_\_ E-mail: \_\_\_\_\_

#### PART A: Medical Information

Limit your response to the medical condition for which the employee is seeking FMLA leave. Your answers should be your **best estimate** based upon your medical knowledge, experience, and examination of the patient. **After completing Part A, complete Part B to provide information about the amount of leave needed.** Note: For FMLA purposes, "incapacity" means the inability to work, attend school, or perform regular daily activities due to the condition, treatment of the condition, or recovery from the condition. Do not provide information about genetic tests, as defined in 29 C.F.R. § 1635.3(f), genetic services, as defined in 29 C.F.R. § 1635.3(e), or the manifestation of disease or disorder in the employee's family members, 29 C.F.R. § 1635.3(b).

(1) Patient's Name: \_\_\_\_\_

(2) State the approximate date the condition started or will start: \_\_\_\_\_ (mm/dd/yyyy)

(3) Provide your **best estimate** of how long the condition lasted or will last: \_\_\_\_\_

(4) For FMLA to apply, care of the patient must be medically necessary. Briefly describe the type of care needed by the patient (e.g., assistance with basic medical, hygienic, nutritional, safety, transportation needs, physical care, or psychological comfort).

\_\_\_\_\_

Employee Name: \_\_\_\_\_

(5) Check the box(es) for the questions below, as applicable. For all box(es) checked, the amount of leave needed must be provided in Part B.

**Inpatient Care:** The patient (  has been /  is expected to be) admitted for an overnight stay in a hospital, hospice, or residential medical care facility on the following date(s): \_\_\_\_\_

**Incapacity plus Treatment:** (e.g. outpatient surgery, strep throat)  
Due to the condition, the patient (  has been /  is expected to be) incapacitated for more than three consecutive, full calendar days from: \_\_\_\_\_ (mm/dd/yyyy) to \_\_\_\_\_ (mm/dd/yyyy).  
The patient (  was /  will be) seen on the following date(s): \_\_\_\_\_

The condition (  has /  has not) also resulted in a course of continuing treatment under the supervision of a health care provider (e.g. prescription medication (other than over-the-counter) or therapy requiring special equipment)

- Pregnancy:** The condition is pregnancy. List the expected delivery date: \_\_\_\_\_ (mm/dd/yyyy).
- Chronic Conditions:** (e.g. asthma, migraine headaches) Due to the condition, it is medically necessary for the patient to have treatment visits at least twice per year.
- Permanent or Long Term Conditions:** (e.g. Alzheimer's, terminal stages of cancer) Due to the condition, incapacity is permanent or long term and requires the continuing supervision of a health care provider (even if active treatment is not being provided).
- Conditions requiring Multiple Treatments:** (e.g. chemotherapy treatments, restorative surgery) Due to the condition, it is medically necessary for the patient to receive multiple treatments.
- None of the above:** If none of the above condition(s) were checked, (i.e., inpatient care, pregnancy) no additional information is needed. Go to page 4 to sign and date the form.

(6) If needed, briefly describe other appropriate medical facts related to the condition(s) for which the employee seeks FMLA leave. (e.g., use of nebulizer, dialysis)

\_\_\_\_\_

**PART B: Amount of Leave Needed**

For the medical condition(s) checked in Part A, complete all that apply. 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 if the benefits and protections of the FMLA apply.

(7) Due to the condition, the patient (  had /  will have) **planned medical treatment(s)** (scheduled medical visits) (e.g. psychotherapy, prenatal appointments) on the following date(s): \_\_\_\_\_

(8) Due to the condition, the patient (  was /  will be) **referred to other health care provider(s)** for evaluation or treatment(s).  
State the nature of such treatments: (e.g. cardiologist, physical therapy) \_\_\_\_\_

Provide your **best estimate** of the beginning date \_\_\_\_\_ (mm/dd/yyyy) and end date \_\_\_\_\_ (mm/dd/yyyy) for the treatment(s).

Provide your **best estimate** of the duration of the treatment(s), including any period(s) of recovery (e.g. 3 days/week)

\_\_\_\_\_

Employee Name: \_\_\_\_\_

(9) Due to the condition, the patient (  was /  will be) **incapacitated for a continuous period of time**, including any time for treatment(s) and/or recovery.

Provide your **best estimate** of the beginning date \_\_\_\_\_ (mm/dd/yyyy) and end date \_\_\_\_\_ (mm/dd/yyyy) for the period of incapacity.

(10) Due to the condition, it (  was /  is /  will be) medically necessary for the employee to be absent from work to provide care for the patient on an **intermittent basis** (periodically), including for any episodes of incapacity i.e., episodic flare-ups. Provide your **best estimate** of how often (frequency) and how long (duration) the episodes of incapacity will likely last.

Over the next 6 months, episodes of incapacity are estimated to occur \_\_\_\_\_ times per (  day  week  month) and are likely to last approximately \_\_\_\_\_ (  hours  days) per episode.

Signature of Health Care Provider \_\_\_\_\_ Date: \_\_\_\_\_ (mm/dd/yyyy)

**Definitions of a Serious Health Condition (See 29 C.F.R. §§ 825.113-.115)**

**Inpatient Care**

- An overnight stay in a hospital, hospice, or residential medical care facility.
- Inpatient care includes any period of incapacity or any subsequent treatment in connection with the overnight stay.

**Continuing Treatment by a Health Care Provider (any one or more of the following)**

**Incapacity Plus Treatment:** A period of incapacity of more than three consecutive, full calendar days, and any subsequent treatment or period of incapacity relating to the same condition, that also involves either:

- o Two or more in-person visits to a health care provider for treatment within 30 days of the first day of incapacity unless extenuating circumstances exist. The first visit must be within seven days of the first day of incapacity; or,
- o At least one in-person visit to a health care provider for treatment within seven days of the first day of incapacity, which results in a regimen of continuing treatment under the supervision of the health care provider. For example, the health provider might prescribe a course of prescription medication or therapy requiring special equipment.

**Pregnancy:** Any period of incapacity due to pregnancy or for prenatal care.

**Chronic Conditions:** Any period of incapacity due to or treatment for a chronic serious health condition, such as diabetes, asthma, migraine headaches. A chronic serious health condition is one which requires visits to a health care provider (or nurse supervised by the provider) at least twice a year and recurs over an extended period of time. A chronic condition may cause episodic rather than a continuing period of incapacity.

**Permanent or Long-term Conditions:** A period of incapacity which is permanent or long-term due to a condition for which treatment may not be effective, but which requires the continuing supervision of a health care provider, such as Alzheimer's disease or the terminal stages of cancer.

**Conditions Requiring Multiple Treatments:** Restorative surgery after an accident or other injury; or, a condition that would likely result in a period of incapacity of more than three consecutive, full calendar days if the patient did not receive the treatment.

**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 15 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 Avenue, N.W., Washington, D.C. 20210.

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