UMBC

AN HONORS UNIVERSITY IN MARYLAND

Department of Human Resources
University of Maryland, Baltimore County
1000 Hilltop Circle
Administration Building, 5th Floor
Baltimore, Maryland 21250

GENERAL INFORMATION: 410-455-2337
FAX: 410-455-1064
VOICE/TTY: 410-455-3233
www.umbc.edu

CONFIDENTIAL

CERTIFICATION OF QUALIFYING EXIGENCY FOR MILITARY FAMILY LEAVE (FAMILY AND MEDICAL LEAVE ACT)

The Military Family and Medical Leave Act (FMLA) Policy is in Section VII.7.50 of the UMBC Policies Website (www.umbc.edu/policies).

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 leave due to a qualifying exigency to submit a certification. Please complete Section I before giving this form to your employee. Your response is voluntary, and 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. § 825.309.

Employer Name: **University of Maryland Baltimore County (UMBC)**

Contact Information:

SECTON II: For Completion by the EMPLOYEE

INSTRUCTIONS to the EMPLOYEE: Please complete Section II fully and completely. The FMLA permits an employer to require that you submit a timely, complete, and sufficient certification to support a request for FMLA leave due to a qualifying exigency. Several questions in this section seek a response as to the frequency or duration of the qualifying exigency. Be as specific as you can; terms such as "unknown, "or "indeterminate" may not be sufficient to determine FMLA coverage. Your response is required to obtain a benefit. 29 C.F.R. § 825.310. While you are not required to provide this information, failure to do so may result in a denial of your request for FMLA leave. Your employer must give you at least 15 calendar days to return this form to your employer.

Your Name	First:	Middle:	Last:

Name of covered military member on active duty or call to active duty status in support of a contingency operation:

First:	Middle:	Last:

Relationship of covered military member to you:	
Period of covered military member's active duty:	

A complete and sufficient certification to support a request for FMLA leave due to a qualifying exigency includes written documentation confirming a covered military member's active duty or call to active duty status in support of a contingency operation. Please check one of the following:

☐ A copy of the covered military member's active duty orders is attached.

☐ Other documentation from the military certifying that the covered military member is on active duty (or has been notified of an impending call to activity duty) in support of a contingency operation is attached.

☐ I have previously provided my employer with sufficient written documentation confirming the covered military member's active duty or call to active duty status in support of a contingency operation.

PART A: QUALIFYING REASON FOR LEAVE

1. Describe the reason you are requesting FMLA leave due to a qualifying exigency (including the specific reason you are requesting leave):

2. A complete and sufficient certification to support a request for FMLA leave due to a qualifying exigency includes any available written documentation which supports the need for leave; such documentation may include a copy of a meeting announcement for informational briefings sponsored by the military, a document confirming an appointment with a counselor or school official, or a copy of a bill for services for the handling of legal or financial affairs. Available written documentation supporting this request for leave is attached.

☐ Yes ☐ No ☐ None Available

PART B: AMOUNT OF LEAVE NEEDED

1. Approximate date exigency commenced:

   Probable duration of exigency:

2. Will you need to be absent from work for a single continuous period of time due to the qualifying exigency.

   ☐ Yes ☐ No

   If so, estimate the beginning and ending dates for the period of absence;

3. Will you need to be absent from work periodically to address this qualifying exigency? ☐ Yes ☐ No

   Estimate schedule of leave, including the dates of any scheduled meetings or appointments:

Estimate the frequency and duration of each appointment, meeting, or leave event, including any travel time (i.e., 1 deployment-related meeting every month lasting 4 hours):

Frequency: _____ times per week _____ week(s) _____ months(s)
Duration: _____ hours _____ day(s) per event.

PART C:

If leave is requested to meet with a third party (such as to arrange for childcare, to attend counseling, to attend meeting switch school or childcare providers, to make financial or legal arrangements, to act as the covered military me members representative before a federal, state, or local agency for purposes of obtaining, arranging, or appealing military service benefits, or to attend any event sponsored by the military or military service organizations), a complete and sufficient certification includes the name, address, and appropriate contact information for the individual or entity with whom you are meeting (i.e., either the telephone or fax number or email address of the individual or entity). This information may be used by your employer to verify that the information contained on this form is accurate.

Name of Individual:	Title:
Organization:	
Address:	
Telephone:	Fax:
Email:	
Describe nature of meeting:	

PART D:

I certify that the information I provided above is true and correct.

Signature of Employee: Date:

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Certification of Physician or Practitioner
Family and Medical Leave Act (FMLA)

Part I: TO BE COMPLETED BY PHYSICIAN OR PRACTITIONER

1. Employee's name:

2. Patient's name *(if other than employee)*:

2a. Relationship to employee:

3. The last page of this packet describes what is meant by a **"serious health condition"** under the Family and Medical Leave Act. Does the patient's condition[1] qualify under any of the categories described? If so, please check the applicable category.

- ☐ **a.** Hospital Care
- ☐ **b.** Absence Plus Treatment
- ☐ **c.** Pregnancy
- ☐ **d.** Chronic Conditions Requiring Treatments
- ☐ **e.** Permanent/Long-Term Conditions Requiring Supervision
- ☐ **f.** Multiple Treatments (Non-Chronic Conditions)

4. Please describe the diagnosis and medical facts which support your certification, including a brief statement as to how the medical facts meet the criteria of one of the above categories:

5. **a.** 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**[2] if different):

b. 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)? ☐ Yes ☐ No

If Yes, please provide the probable duration:

c. If the condition is a **chronic condition** (condition d) or **pregnancy**, state whether the patient is presently incapacited[2] and the likely duration and frequency of **episodes of incapacity**[2]:

[1] Here and elsewhere on this form, the information sought relates **only** to the condition for which the employee is taking FMLA leave.

[2] "Incapacity," for 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 there from.

6. **a.** If additional **treatments** will be required for the condition, please 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 of and interval between such treatments, actual or estimated dates of treatment if known, and period required for recovery if any:

b. If any of these treatments will be provided by **another provider of health services** (e.g., physical therapist), please state the nature of the treatments:

c. **If a regimen of continuing treatment** by the patient is required under your supervision, please provide a general description of such regimen (e.g., prescription drugs, physical therapy requiring special equipment):

7. **a.** 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? ☐ Yes ☐ No

Further explanation (if needed):

b. 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)? ☐ Yes ☐ No

If Yes, please list the essential functions the employee is unable to perform:

c. If neither a. nor b. applies, is it necessary for the employee to be **absent from work for treatment**?

☐ Yes ☐ No

8. **a.** 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? ☐ Yes ☐ No

b. If no, would the employee's presence to provide **psychological comfort** be beneficial to the patient or assist in the patient's recovery? ☐ Yes ☐ No

c. If the patient will need care only **intermittently** or on a part-time basis, please indicate the probable **frequency** and **duration** of this need:

Name of Health Care Provider (please print):	Signature of Health Care Provider:	Type of Practice:
Address:		
Telephone Number:	Date:	

The physician or practitioner's certification may be returned to the employee or mailed to the following address for proper review and processing:

University of Maryland Baltimore County (UMBC)
Department of Human Resources
Attention: Mrs. Michele Kimery
Administration Building, Room 504
1000 Hilltop Circle
Baltimore, Maryland 21250

Part II: 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 a full schedule:

Employee Signature: Date:

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

1. Hospital Care

   Inpatient care (i.e., an overnight stay) in a hospital, hospice, or residential medical care facility, including any period of incapacity[2] or subsequent treatment n connection with or consequent to such inpatient care.

2. Absence Plus Treatment

   (a) A period of incapacity[2] of **more than three consecutive calendar days** (including any subsequent treatment or period of incapacity[2] 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 a 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:

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

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

   (3) May cause **episodic** rather than a continuing period of incapacity[2] (e.g., asthma, diabetes, epilepsy, etc.).

5. Permanent/Long-term Conditions Requiring Supervision

   A period of **Incapacity**[2] 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 need 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**[2] **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), and kidney disease (dialysis).

[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 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.

The next section is for:

Certification for Serious Injury or Illness of Covered Servicemember for Military Family Leave (Family and Medical Leave Act)

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Certification for Serious Injury or Illness of Covered Servicemember for Military Family Leave (Family and Medical Leave Act)

Notice to the EMPLOYER INSTRUCTIONS to the EMPLOYER:

The family and Medical Leave Act (FMLA) provides that an employer may require an employee seeking FMLA leave due to a serious injury or illness of a covered servicemember to submit a certification providing sufficient facts to support the request for leave. 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. § 1630.14(c)(1), if the Americans with Disabilities Act applies.

SECTION I: For Completion by the EMPLOYEE and/or the COVERED SERVICEMEMBER for whom the Employee is Requesting Leave INSTRUCTIONS to the EMPLOYEE or COVERED SERVICEMEMBER:

Please complete Section I before having Section II completed. The FMLA permits and employer to require that an employee submit a timely, complete, and sufficient certification to support a request for FMLA leave due to a serious injury or illness of a covered servicemember. If requested by the employer, your response is required to obtain or retain the benefit of FMLA-protected leave. 29 U.S.C. §§ 2613, 2614 (c)(3). Failure to do so may result in a denial of an employee's FMLA request. 29 C.F.R. § 825.310(f). The employer must give an employee at least 15 calendar days to return this form to the employer.

SECTION II: For Completion by a UNITED STATES DEPARTMENT OF DEFENSE ("DOD") HEALTH CARE PROVIDER or a HEALTH CARE PROVIDER who is either: (1) a United States Department of Veterans Affairs ("VA") health care provider: (2) a DOD TRICARE network authorized private health care provider; or (3) a DOD non-network TRICARE authorized private health care provider INSTRUCTIONS to the HEALTH CARE PROVIDER:

The employee listed on Page 2 has requested leave under the FMLA to care for a family member who is a member of the Regular Armed Forces, the National Guard, or the Reserves who is undergoing medical treatment, recuperation, or therapy, is otherwise in outpatient status, or is otherwise on the temporary disability retired list for a serious injury or illness. For purposes of FMLA leave, a serious injury or illness is one that was incurred in the line of duty on active duty that may render the servicemember medically unfit to perform the duties of his or her office, grade, rank, or rating.

A complete and sufficient certification to support a request for FMLA leave due to a covered servicemember's serious injury or illness includes written documentation confirming that the covered servicemember's injury or illness was incurred in the line of duty on active duty and that the covered servicemember is undergoing treatment for such injury or illness by a health care provider listed above. Answer, fully and completely, all applicable parts. Several questions seek a response as to the frequency or duration of a condition, treatment, etc. Your answers 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 response to the condition for which the employee is seeking leave.

Certification for Serious Injury or Illness of Covered Servicemember for Military Family Leave (Family and Medical Leave Act

SECTION I: For Completion by the EMPLOYEE and/or the COVERED SREVICEMEMBER for whom the Employee Is Requesting Leave: (This section must be completed first before any of the below sections can be completed by a health care provider.)

Part A: EMPLOYEE INFORMATION

Name and Address of Employer (this is the employer of the employee requesting leave to care for covered servicemember):

Name of Employee Requesting Leave to Care for Covered Servicemember:

First:	Middle:	Last:

Name of Covered Servicemember (for whom employee is requesting leave to care):

First:	Middle:	Last:

Relationship of Employee to Covered Servicemember Requesting Leave to Care:

Part B: COVERED SERVICEMEMBER INFORMATION

1. Is the Covered Servicemember a Current Member of the Regular Armed Forces, the National Guard or Reserves ? ☐Yes ☐ No

If yes, please provide the covered servicemember's military branch, rank and unit currently assigned to:

Is the covered servicemember assigned to a military medical treatment facility as an outpatient or to a unit established for the purpose of providing command and control of members of the Armed Forces receiving medical care as outpatients (such as a medical hold or warrior transition unit)? ☐ Yes ☐ No

If yes, please provide the name of the medical treatment facility or unit:

2. Is the Covered Servicemember on the Temporary Disability Retired List (TDRL)? ☐ Yes ☐ No

Part C: CARE TO BE PROVIDED TO THE COVERED SERVICMEMBER

Describe the Care to Be Provided to the covered Servicemember and an Estimate of the Leave Needed to Provide the Care:

SECTION II: For Completion by a United States Department of Defense ("DOD") Health Care Provider of a Health care Provider who is either: (1) a United States Department of Veterans Affairs ("VA") health care provider; (2) a DOD TRICARE NETWORK AUTHORIZED PRIVATE HELTH CARE PROVIDER; OR (3) A DOD non-network TRICARE authorized private health care provider.

If you are unable to make certain of the military-related determinations contained below in Part B, you are permitted to rely upon determinations from an authorized DOD representative (such as a DOD recovery care coordinator). (Please ensure that Section I above has been completed before completing this section). Please be sure to sign the form on the last page.

Part A: HELTH CARE PROVIDER INFORMATION

Health Care Provider's Name and Business Address:

Type of Practice/Medical Specialty:

Please state whether you are either**: (1)** a DOD health care provider; **(2)** a VA health care provider; **(3)** a DOD TRICARE network authorized private health care provider; or **(4)** a DOD non-network TRICARE authorized private health care provider:

☐ **1** ☐ **2** ☐ **3** ☐ **4**

Telephone:	Fax:	Email:

Part B: MEDICAL STATUS

1. Covered Service member's medical condition is classified as (Check One of the appropriate Boxes):

☐ **(VSI) Very Serious Ill/Injury –** Illness/Injury is of such a severity that life is imminently endangered. Family members are requested at bedside immediately. (Please note this is an internal DOD casualty assistance designation used by DOD healthcare providers.)

☐ **(SI) Seriously Ill/Injured** – Illness/Injury is of such severity that there is cause for immediate concern, but there is not imminent danger to life. Family member are requested at bedside. (please not this is an internal DOD casualty assistance designation used by DOD healthcare providers.)

☐ **OTHER Ill/Injury** – a serious injury or illness that may render the servicemember medically unfit to perform the duties of the member's office, grade, rank or rating.

☐ **NONE OF THE ABOVE** – (Note to Employee: If this box is checked, you may still be eligible to take leave to care for a covered family member with a "serious health condition" under § 825.113 of the MFLA. If such leave is requested, you may be required to complete DOL FORM WH-380 or an employer-provided for seeking the same information).

2. Was the condition for which the Covered Service member is being incurred in line of duty on active duty in the armed forces? ☐ Yes ☐ No

3. Approximate date condition commenced:

4. Probable duration of condition and/or need for care:

5. Is the covered serivemember undergoing medical treatment, recuperation, or therapy? ☐ Yes ☐ No. If yes, please describe medical treatment, recuperation or therapy:

Part C: COVERED SERVICEMEMBER'S NEED FOR CARE BY FAMILY MEMBER

1. Will the covered servicemember need care for a single continuous period of time, including any time for treatment and recovery?

☐ Yes ☐ No

If yes, estimate the beginning and ending date for this period of time:

2. Will the covered servicemember require periodic follow-up treatment appointments?

☐ Yes ☐ No

If yes, estimate the treatment schedule:

3. Is there a medical necessity for the covered servicemember to have periodic care for these follow-up treatment appointments?

☐ Yes ☐ No

4. Is there a medical necessity for the covered servicemember to have periodic care for other than scheduled follow-up treatment appointments (e.g., episodic flare-ups of medical condition)?

☐ Yes ☐ No

If yes, please estimate the frequency and duration of the periodic care:

Signature of Health Care Provider:	Date:

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Notification for Family and Medical Leave Act (FMLA)

For Human Resources Use Only

To:	Date:

Your request for ☐ continuous or ☐ intermittent leave under the FMLA and supporting documentation that you have provided were received and reviewed by the Department of Human Resources. Based on the review of information, the following have been concluded:

☐ Your FMLA Leave request is approved.

☐ You are required to exhaust all of your available accrued leave during your FMLA absence. This means that your leave usage will be counted against your FMLA leave entitlement.

☐ Contact _____ at _____ to make arrangements to continue to make your share of the premium payments to maintain health benefits while you are on unpaid leave. You have a minimum 30-day (or, indicated longer period, if applicable) grace period in which to make premium payments. If payment is not made in a timely manner, your group health benefits may be cancelled.

☐ You will be required to present a fitness-for-duty certificate to be restored to employment. If such certification is not received in a timely manner, your return to work may be delayed until certification is provided.

☐ Your FMLA Leave request is not approved.

☐ The FMLA does not apply to your leave request.

☐ You have exhausted your FMLA leave entitlement in the applicable 12-month period.

☐ Additional information is needed to determine if your FMLA leave request can be approved. Such information consist of

☐ The certification you have provided is not complete and insufficient to determine whether the FMLA applies to your leave request. You must provide the following information no later than _____, unless it is not practicable under the particular circumstances despite your diligent good faith efforts, or your leave may be denied. Information needed to make the certification complete and sufficient:

Additional Comments:

Signature of Human Resources' Designee: Date:

FMLA Notice 04032009