

MORGAN STATE UNIVERSITY
Request for Family and Medical Leave

EMPLOYEE INFORMATION	
1. Name: Social Security #:	2. Title: Department:
3. Reason for requesting leave: a. Birth of a 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 (please answer #4 and #5 below); d. Serious health condition which makes me unable to perform the functions of my position; or e. Armed Services member Family Leave (up to 26 weeks).	
4. If 3c 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? <div style="display: flex; justify-content: space-around;"> Yes* No </div> <p><small>*If yes, please provide a certification from a health care provider justifying the necessity for intermittent leave. The HR45 form may be used for this justification. On a separate sheet, give a schedule of when you anticipate you will be unavailable for work.</small></p>	
9. I wish to use paid and/or unpaid leave. (The Office of Human Resources may make the decision that paid leave must be used if it has such a written policy.)	
<p>Employees seeking leave because of Reason 3c or 3e <u>must</u> have a health care provider complete the Certification of Health Care Provider Form (HR45) and return to the Office of Human Resources within fifteen (15) days, or as soon as practicable. Leave may be delayed until a completed HR45 is provided. Employees seeking to return to work after a leave because of Reason 3d <u>also</u> must complete the Return to Work Medical Certification Form (HR46) before they will be allowed to resume work. Employees may not be permitted to resume any position until a completed Return to Work Medical Certification (HR46) is provided.</p>	
<u>EMPLOYEE AGREEMENT</u>	
<p>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. I also agree that if I fail to return to work at the end of the leave period, I will reimburse my agency 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 FMLA leave, I will contact the Office of Human Resources after I have been on leave thirty calendar days and at the end of each 30-day period afterwards.</p>	
Signed:	Date:

