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FAMILY MEDICAL LEAVE ACT (FMLA)/LEAVE OF ABSENCE (LOA) REQUEST FORM

Return completed form to:
Prince George's County Public Schools, Absence Management Office
14201 School Lane, Upper Marlboro, MD 20772
Phone: 301-952-6200. Fax: 301-760-3593 Email:absence.mgmt@pgcps.org

PLEASE NOTE:

- Family and Medical Leave Act (FMLA) is unpaid leave. You can request to use all accrued Annual, Sick, and Personal leave.
- Employee will be notified as to the status of their leave request after Absence Management has reviewed the request. Supporting documentation*** must be provided.
- Employee must complete all fields in Sections 1 and 2. Employee's supervisor ***must*** complete Section 3 to acknowledge receipt of the request for leave.
- By signing below, I authorize all treating provider(s) to release information obtained in the course my evaluation and treatment to Absence Management. Further, I grant Absence Management permission to verify all supporting documents to determine eligibility and FMLA entitlements. Absence Management can share my medical information with any health care provider consulted for further medical opinion on my behalf.

Section 1. Employee's Information *(please print)*

FMLA Start Date:	**FMLA Expected Return to Work Date:**		
Name: (Last, First, Middle Initial)	**EIN:**	**Position:**	**Today's Date:**

Your contact information *while on leave*:

Address: _____

Phone Number: _____ **Email:** _____

Your Work Location (Name of School or Department):

Is this health condition related to work injury? ☐ **Yes** ☐ **No** **Worker's Compensation Claims #**

Do you elect to use your projected leave? ☐ **Yes** ☐ **No (projected leave is subject for review).**

Do you elect to use: personal/annual leave ☐ **Yes** ☐ **No; sick leave** ☐ **Yes** ☐ **No to cover your FMLA/LOA leave?**
(You must make a selection. If no selection is made you will automatically be charged earned sick leave)

If maternity/paternity, number of weeks requested _____ (12 weeks Maximum)
Please remember to add your newborn to your benefits through Oracle Self-Service within 30 days of birth. If you need assistance contact Benefits Services at 301-952-6600.

Section 2. Reason for Leave Request – Select one of the following:

- ◯ Your own serious health condition that makes you unable to perform your job. ***A Certificate of Medical Release is required ten (10) days prior to the employee's return.*** ***Medical Releases submit with the original request will not be processed if it is not within 10 days of your official return to work date.***
- ◯ Incapacity due to Pregnancy, Prenatal Medical Care, or Childbirth
- ◯ To care for your child after birth, or placement for adoption or foster care
- ◯ To care for your family member who has a serious health condition
  - ◯ Spouse
  - ◯ Child
  - ◯ Parent
- ◯ Military Family Leave
  - ◯ Qualified Exigency
  - ◯ To care for an injured or ill service member or veteran

Employee Signature: _____ **Date:** _____

Section 3. Supervisor's Acknowledgment is Required

Supervisor Printed Name: _____

Supervisor Signature: _____ **Date:** _____

***** This form must be submitted within thirty days prior to the requested leave start date or as soon as practical in emergency circumstances. Failure to submit the required documentation will result in an *Ineligible Leave Request*. This form can be found on the PGCPS website (https://www.pgcps.org/offices/business-management-services/payroll-services/absence-management /) or by contacting the Absence Management Office at absence.mgmt@pgcps.org.**

Due to HIPPA LAW: This page should be kept confidential and provided to Absence Management ONLY upon completion

To be completed by the Employee:

Employee's/Caregiver's Name_____ **EIN:**_____

Select if this request is for your personal illness ☐ **or for your family member's illness (Caregiver)** ☐

SECTION 4. TO BE COMPLTED BY THE PHYSICIAN

Where indicated, your documentation should provide specific dates. Terms such as, "lifetime," "unknown," or "unable to determine" will not be sufficient to determine eligibility for an extended leave. If medical decision requires documentation of uncertain frequency and uncertain duration of a condition, your best estimation of time and frequency is required.

PART A: FOR EMPLOYEE'S OWN ILLNESS ONLY (Do not complete this section if the person is serving as a Caregiver):

Approximate start date of the serious health condition: _____

What is the usual recovery period for this condition? _____

If overnight stay in a hospital, hospice, or residential medical care facility: Date:_

Surgery/Procedure: _____**Date:** _____

Is this a pregnancy? _____ ☐ **Yes** ☐ **No. If so, expected delivery date:** _____

PART B: REQUIRED DOCUMENTATION OF SERIOUS HEALTH CONDITION BY THE HEALTH CARE PROVIDER

Must be completed for the Employee's Illness or for the Caregiver's Family Member

Diagnosis & ICD Code(s)	Prognosis	Severity of the Health Condition	Impact on Essential Job Function

PART C: AMOUNT OF LEAVE NEEDED: Must be completed for the Employee's Illness or for the Caregiver's Family Member

Selection one option only:

All requests are required to have an estimated ending date in order to determine eligibility. This will not be used as an official release date.

☐ **Will this be for a continuous period, including any time for treatment and recovery?**

Beginning date: _____/_____/_____ **Ending date:** _____/_____/_____
Month Day Year Month Day Year **(estimated ending date)**

☐ **Will this be for an intermittent period of time and the employee will/can continue to work? Frequency of treatment/recovery: # of days per month** _____**(8 days max).**

Beginning date: _____/_____/_____**Ending date:** _____/_____/_____
Month Day Year Month Day Year **(estimated ending date)**

SPACE FOR ADDITIONAL INFORMATION (IF NEEDED):

_____

I declare under penalty of perjury that I have examined all the information on this form, and on any accompanying statements or forms, and it is true and correct to the best of my knowledge. I understand that anyone who knowingly gives a false or misleading statement about a material fact in this information, or causes someone else to do so, commits a crime and may be sent to prison, or may face other penalties, or both.

Health Care Provider's Name: _____**Provider's ID#** _____**(Required)**

Type of Specialty: _____

Business Address: _____**Telephone:** _____

Signature of Health Care Provider: _____**Date:**_____

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