

The Maryland-National Capital Park and Planning Commission
Application to Use Paid Leave for Family, Medical or Military Leave

To be completed by employee

Employee Name: _____ Employee ID Number: _____

Work Location: _____ Supervisor: _____

Reason For Leave

- Birth of child(ren) (medical certification attached) Adoption or foster care (court order attached)
- Serious health condition that makes me unable to perform the essential functions for my position
(medical certification attached)
- Serious health condition affecting my
 spouse child parent for which I am needed to provide care (medical certification attached)
- Family member in military: qualifying exigency
- Family Member in military: serious injury or illness of service member

Date Leave Period Begins _____ **Date Leave Ends (Through)** _____

Requested Leave Types: Relevant Merit Rule Sections: 1470,1633 & 1642 may apply. Rank each leave type in the order you would like to use them, with 1 as your top choice and 5 as your last choice.

Sick Leave: Order of use _____	Amount _____	<input type="checkbox"/> Hours	<input type="checkbox"/> Days
Compensatory Leave: Order of use _____	Amount _____	<input type="checkbox"/> Hours	<input type="checkbox"/> Days
Annual Leave: Order of use _____	Amount _____	<input type="checkbox"/> Hours	<input type="checkbox"/> Days
Personal Leave: Order of use _____	Amount _____	<input type="checkbox"/> Hours	<input type="checkbox"/> Days
Leave Without Pay: Order of use _____	Amount _____	<input type="checkbox"/> Hours	<input type="checkbox"/> Days

Work Schedule (intermittent leave use only). Provide your expected work schedule, including specific days and hours you plan to work _____

- Leave requests based on a serious health condition must be accompanied by a verifying medical certification from a licensed provider authorized to practice in the state or country in which the services are rendered, on the appropriate Certification of Health Care Provider form. (Employee, Family Member or Military)
- Leave requests based on a serious health condition for a family member or military family member must be documented by a United States or Department of Defense (DOD) authorized health care provider or an authorized DOD representative if the provider is unable to make certain military-related determinations as outlined in the FMLA.
- During periods of leave without pay, I will be responsible for contacting the Health & Benefits Office and paying the employee share of health insurance benefit premiums.
- I must provide a return to work certificate from my provider prior to being restored to employment. Certification must address any work restrictions, indicate whether restrictions are permanent or temporary and the expected date I will return to full duty from the restrictions. My return to work may be delayed until certification is provided. (M-NCPPC form)
- Department Head approval will now be documented on a Department of Labor form.

Employee SIGNATURE: _____ DATE: _____