UNIVERSITY SYSTEM OF MARYLAND

Form 4 – Designation Notice

Federal Family and Medical Leave (FMLA) and/or Maryland Paid Family and Medical Leave (PFML)

Confidential – HR Use Only

Date Issued: _____ Original Leave Request Date: _____

Employee Name: _____ UID / Employee ID: _____

Institution: _____ Leave Start Date (if known): _____

After review of your leave request and any required certification, the University has determined the following:

Section I – Designation Determination

A. FMLA Determination (check one):

- ○ Your leave is approved and designated as FMLA leave.
- ○ Your leave is approved in part and designated as FMLA leave.
- ○ Your leave does not qualify for FMLA.
- ○ Conditional designation pending receipt of complete and sufficient certification.

If denied or partially approved, provide explanation: _____

_____

_____

_____

FMLA Measurement Period

FMLA leave is measured using a 12 month period measured forward from the first date an employee takes FMLA leave.

Your FMLA period begins on: _____

If military caregiver leave: ☐ Military caregiver leave approved.

Single 12-month period measured forward from: _____ (first day of military caregiver leave)

FMLA Hours Designated to Date (if known): _____

FMLA Hours Remaining (if known): _____

B. PFML Determination (check one)

- ○ Your leave is approved and designated as PFML leave.
- ○ Your leave is approved in part and designated as PFML leave.
- ○ Your leave does not qualify for PFML.
- ○ Conditional designation pending receipt of required documentation.

If denied or partially approved, provide explanation: _____

_____

_____

_____

PFML Application Year

Your PFML Application Year begins on the Sunday of the calendar week in which PFML leave begins: _____ (Sunday anchor date)

PFML Hours Designated to Date (if known): _____

PFML Hours Remaining (if known): _____

Section II – Designated Leave Schedule

○ Continuous Leave. Approved Period: From _____ To _____

○ Intermittent Leave. Approved Frequency: _____.
Approved Duration per Episode: _____

○ Reduced Schedule Leave. Approved Work Schedule: _____

_____

_____

For PFML, intermittent leave may not be taken in increments of less than four (4) hours.

If actual leave usage differs materially from the certification provided, additional documentation may be required.

Section III – Pay Status

☐ FMLA leave is unpaid unless the leave has also been designated as PFML qualifying or accrued leave is substituted in accordance with policy.

☐ PFML leave will be paid at the employee's regular rate of pay in accordance with applicable policy.

Accrued leave substitution (if applicable): _____

_____

Section IV – Benefits Continuation

During approved FMLA and/or PFML leave, group health insurance will generally continue under the same terms as if you were actively employed.

You remain responsible for your share of required premium contributions. Failure to timely pay required premiums may result in loss of coverage.

If you do not return to work following unpaid FMLA leave (subject to permitted exceptions), the University may seek recovery of the employer share of premiums paid during the unpaid FMLA period.

Section V – Fitness-For-Duty (If Applicable)

○ A fitness-for-duty certification will be required prior to return to work.

○ A fitness-for-duty certification is not required.

If required, the certification must confirm the employee's ability to perform essential job functions.

Section VI – Job Protection and Rights

If eligible and approved, FMLA and/or PFML leave is job-protected in accordance with applicable law.

Upon return from approved leave, you will generally be restored to the same or an equivalent position, subject to statutory exceptions.

The University prohibits interference with, restraint of, or retaliation against any employee for exercising rights under FMLA or PFML.

Section VII – Reconsideration / Appeal

If you disagree with this designation determination, you may submit a written request for reconsideration within ten (10) business days of this notice, including any additional documentation you wish to have considered.

Submit requests to:

Leave Administrator Name: _____

Email: _____ Phone: _____

Section VIII – HR Authorization

Authorized HR Representative: _____ Title: _____

Signature: _____ Date: _____