**MCPS – MCEA FAMILY MEDICAL CRISIS LEAVE BANK**

**REQUEST FORM**

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Employee ID No.: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Home Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Work Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

School/Dept.: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Cell Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**WHICH FAMILY MEMBER IS INJURED OR ILL? Please circle one: Parent Spouse Child Sibling**

I am hereby requesting that the MCPS-MCEA Family Medical Crisis Leave Bank (FMCLB) provide leave for me in relationship to current catastrophic and life threatening illness or injury to a member of my immediate family.

I/We further understand and authorize the FMCLB, as part of its consideration of my request to review medical documents submitted to MCPS related to this request. I/We waive any claim that I/We might have now or in the future, against MCEA or the Montgomery County Public Schools, their employees, agents, servants, assigns, etc. regarding the review of information (personal, medical or otherwise) pertaining to my request.

Family member’s name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Specific relationship: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

This form must be signed by the employee requesting benefits.

Employee Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date all available leave will be exhausted: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Dates of requested leave coverage: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**PLEASE ATTACH THE REQUIRED PHYSICIAN STATEMENT OF ILLNESS OR INJURY, INCLUDING EXPLANATION OF ASSISTANCE NEEDED, DURATION OF REQUIRED ABSENCE.**

***Return this completed form to Mary Neal***

12 Taft Court, Rockville, MD 20850

301-294-6232

mneal@mceanea.org

Fax: 301-309-9563

***Do not write below this line—***

**FOR FMCLB COMMITTEE MCPS OFFICE OF EMPLOYEE AND RETIREE SERVICES**

Approved \_\_\_\_\_\_\_\_\_\_ # of Days\_\_\_\_\_\_\_\_\_\_ Approved: Yes \_\_\_\_\_\_ No \_\_\_\_\_\_

Denied \_\_\_\_\_\_\_\_\_\_ Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_

Chairperson Signature

**PAYROLL DEPARTMENT**

Date Processed \_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date Reviewed & Posted \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature Payroll Department Representative: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_