FAMILY MEDICAL LEAVE ACT (FMLA)
NOTIFICATION FORM

DATE: _____

TO: Enrollment Unit
Employee Benefits Division

FROM: Name: _____

Agency: _____

Agency Code:_____

Phone No: _____

Fax No: _____

Email: _____

The following individual is being enrolled in FMLA: ☐ New ☐ Intermittent ☐ Extension

Employee Name: _____

Employee SSN: _____

Departing Date: _____

Returning Date:_____

Appropriation Code: ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___
Agency PCA TC R Stars Sub Object

Special Note: FMLA Notice of Eligibility and Rights & Responsibility must be attached for both initial enrollment and extensions.

Fax to: **(410) 333-5191** Or Mail To: Employee Benefits Division
Attn: Enrollment Unit
301 W. Preston Street
Baltimore, MD 21201

Revised 06/11