

**MCPS/MCAAP FAMILY MEDICAL CRISIS LEAVE BANK**  
**ENROLLMENT FORM**

30 West Gude Drive, Suite. 100  
Rockville, Maryland 20850  
301-762-8174

The Family Crisis Leave Bank (FMCLB) is to provide family illness leave to Unit members who have exhausted **ALL** available forms of sick, personal, and annual leave. The FMCLB is solely for situations for catastrophic and life threatening illness or injury to members of the immediate family (child, parent, brother, sister, husband, or wife, anyone who lives regularly in the unit member's household, anyone for whom the unit member has durable medical or personal representative power of attorney, or a person who raised the unit member in lieu of a parent)) that require the; unit member to be temporarily absent from his/her assignment. This leave is **NOT** available for the employees' personal illness or injury.

Unit members may join the Family Medical Crisis Leave Bank (FMCLB) only during the initial enrollment period, during the first 30 calendar days of employment with MCPS, or during the first full work month of any fiscal year. Except for the initial enrollment for current employees, a FMCLB member will have a waiting period of 6 calendar months after joining the FMCLB before being eligible to apply for benefits from the bank.

In order to become a member of the FMCLB I will contribute one day of sick leave to the FMCLB (pro-rated for part-time employees). I understand that FMCLB members will be assessed additional leave time as needed in the future in order to maintain the solvency of the Bank. At the time of any such assessment I will have the right to terminate my membership in the FMCLB and not be assessed additional leave. I understand that this contribution, once donated, is **NOT** available for me to use for any future purpose or benefit.

Name: _____	Employee ID No.: _____
Address: _____	Home Phone: _____
_____	Work Phone: _____
School/Dept.: _____	Cell Phone: _____
Signature _____	Date: _____

DATE RECEIVED: \_\_\_\_\_

**FMCLB COMMITTEE**

Verified \_\_\_\_\_ By \_\_\_\_\_  
date name

\_\_\_\_\_  
Committee Representative

**MCPS EMPLOYEE AND RETIREE SERVICE CENTER**

Approved: \_\_\_Yes \_\_\_No

\_\_\_\_\_  
Authorized Signature / Date

***Return this completed form to: MCAAP FMCLB, 30 West Gude Drive, Suite 100, Rockville, MD 20850***