Family and Medical Leave Request Form **THE CITY UNIVERSITY OF NEW YORK**

Hostos Community College

Eligible employees are entitled to up to 12 weeks of unpaid job-protected leave for certain family and medical reasons. If you wish to request family and medical leave under the CUNY FMLA Policy, submit this completed request form to your Human Resources Director/Personnel Officer as early as practicable, preferably no fewer than 30 days in advance of the start of your leave**. If requesting intermittent or reduced schedule leave, you must attempt to work out a schedule with your supervisor which meets your needs without unduly disrupting your department's operations.** CUNY reserves the right to deny or postpone leave for failure to give appropriate notice.

(Please Type or Print)

1._____
LAST NAME FIRST NAME MIDDLE INITIAL

_____
JOB TITLE DEPARTMENT

2. REASON FOR REQUESTING LEAVE --please check the appropriate box.

- ❑ A. My own serious health condition (Certification of Health Care Provider required.)
- ❑ B. Birth of my child; to care for my new born child – Date of birth: _____ (Appropriate documentation required)
- ❑ C. Placement of child with me for adoption or foster care. Date of placement: _____ (Appropriate documentation required)
- ❑ D. To care for my family member (including spouse, domestic partner, child or parent) with a serious health condition. (Certification of Health Care Provider and proof of relationship required.)
- ❑ E. To care for a seriously injured or ill service member
- ❑ F. Family member called to active duty in the military.

Name/Relationship: _____. Please identify documentation on file_____

3. I request CONTINUOUS FMLA LEAVE starting (date): _____ and ending (date): _____.

4. I request INTERMITTENT FMLA LEAVE starting (date): _____. My anticipated schedule of absence is as follows (attach an additional sheet if needed):

_____

5. I request FMLA LEAVE in the form of a REDUCED WORK SCHEDULE from _____ hours/week to _____hours/week starting (date): _____ and ending (date): _____.

6. Intermittent or reduced work schedule leave is medically necessary because: (attach an additional sheet if needed):

_____

EMPLOYEE STATEMENT OF UNDERSTANDING

I am aware of and understand the following:

- I must return a completed medical certification form to the Human Resources Director/Personnel Officer within 15 days of submitting this request, or as soon as practicable. Failure to do so may result in my leave being delayed until I provide this documentation;
- Before I return to work following a leave for my own serious illness, I may be required to present a fitness for duty certification to the Human Resources Director/Personnel Officer;
- My health benefits will continue during my leave and I am expected to continue to pay my share of health insurance premiums, if any;
- If, under current University leave policies, I am eligible to lengthen this leave or request other leave benefits, I will submit the appropriate documents to the Human Resources Director/Personnel Officer prior to the conclusion of my family and medical leave; and,
- If I fail to return to work upon the conclusion of this leave, I may be subject to disciplinary proceedings or other action in accordance with CUNY policies, rules and regulations, and applicable collective bargaining agreements.

_____ Date: _____
Signature of Employee

Received by:_____ Date:_____
Human Resources Director/Personnel Officer

Certification of Qualifying Exigency
For Military Family Leave
(Family and Medical Leave Act)

THE CITY UNIVERSITY OF NEW YORK

HOSTOS COMMUNITY COLLEGE

SECTION I: For Completion by the EMPLOYER

INSTRUCTIONS to the EMPLOYER: The Family and Medical Leave Act (FMLA) provides that an employer may require an employee seeking FMLA leave due to a qualifying exigency to submit a certification. Please complete Section I before giving this form to your employee. Your response is voluntary, and while you are not required to use this form, you may not ask the employee to provide more information than allowed under the FMLA regulations.

Employer name: _____

Contact Information: _____

SECTION II: For Completion by the EMPLOYEE

INSTRUCTIONS to the EMPLOYEE: Please complete Section II fully and completely. The FMLA permits an employer to require that you submit a timely, complete, and sufficient certification to support a request for FMLA leave due to a qualifying exigency. Several questions in this section seek a response as to the frequency or duration of the qualifying exigency. Be as specific as you can; terms such as "unknown," or "indeterminate" may not be sufficient to determine FMLA coverage. Your response is required to obtain a benefit. While you are not required to provide this information, failure to do so may result in a denial of your request for FMLA leave. Your employer must give you at least 15 calendar days to return this form to your employer.

Your Name: _____
First Middle Last

Name of covered military member on active duty or call to active duty status in support of a contingency operation:

_____
First Middle Last

Relationship of covered military member to you: _____

Period of covered military member's active duty: _____

A complete and sufficient certification to support a request for FMLA leave due to a qualifying exigency includes written documentation confirming a covered military member's active duty or call to active duty status in support of a contingency operation. Please check one of the following:

___ A copy of the covered military member's active duty orders is attached.
___ Other documentation from the military certifying that the covered military member is on active duty (or has been notified of an impending call to active duty) in support of a contingency operation is attached.
___ I have previously provided my employer with sufficient written documentation confirming the covered military member's active duty or call to active duty status in support of a contingency operation.

PART A: QUALIFYING REASON FOR LEAVE

1. Describe the reason you are requesting FMLA leave due to a qualifying exigency (including the specific reason you are requesting leave):

_____

_____

_____

2. A complete and sufficient certification to support a request for FMLA leave due to a qualifying exigency includes any available written documentation which supports the need for leave; such documentation may include a copy of a meeting announcement for informational briefings sponsored by the military, a document confirming an appointment with a counselor or school official, or a copy of a bill for services for the handling of legal or financial affairs. Available written documentation supporting this request for leave is attached. __ Yes __ No __ None Available

PART B: AMOUNT OF LEAVE NEEDED

1. Approximate date exigency commenced: _____ __

   Probable duration of exigency: _____

2. Will you need to be absent from work for a single continuous period of time due to the qualifying exigency? ___No ___Yes.

   If so, estimate the beginning and ending dates for the period of absence:

   _____

3. Will you need to be absent from work periodically to address this qualifying exigency? ___No ___. Yes

   Estimate schedule of leave, including the dates of any scheduled meetings or appointments:

   _____

   _____

   _____

   _____

   Estimate the frequency and duration of each appointment, meeting, or leave event, including any travel time (i.e., 1 deployment-related meeting every month lasting 4 hours):

   Frequency: _____ times per _____ week(s) _____ month(s)

   Duration: _____ hours ____ day(s) per event.

PART C:

If leave is requested to meet with a third party (such as to arrange for childcare, to attend counseling, to attend meetings with school or childcare providers, to make financial or legal arrangements, to act as the covered military member's representative before a federal, state, or local agency for purposes of obtaining, arranging or appealing military service benefits, or to attend any event sponsored by the military or military service organizations), a complete and sufficient certification includes the name, address, and appropriate contact information of the individual or entity with whom you are meeting (i.e., either the telephone or fax number or email address of the individual or entity). This information may be used by your employer to verify that the information contained on this form is accurate.

Name of Individual: _____ Title: _____

Organization: _____

Address: _____

Certification of Qualifying Exigency
For Military Family Leave

THE CITY UNIVERSITY OF NEW YORK

(Family and Medical Leave Act)

HOSTOS COMMUNITY COLLEGE

Telephone: (_____)_____ Fax: (_____)_____

Email: _____

Describe nature of meeting: _____

_____

_____

_____

_____

_____

_____

_____

_____

PART D:

I certify that the information I provided above is true and correct.

_____ _____

Signature of Employee Date