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

The Family and Medical Leave Act (FMLA) provides that an employer may require an employee seeking FMLA leave due to a serious injury or illness of a covered service member to submit a certification providing sufficient facts to support the request for leave. Your response is voluntary. Employers must generally maintain records and documents relating to medical certifications, recertifications, or medical histories of employees or employees' family members, created for FMLA purposes as confidential medical records in separate files/records from the usual personnel files.

SECTION I: For Completion by the EMPLOYEE and/or the COVERED SERVICE MEMBER for whom the Employee Is Requesting Leave INSTRUCTIONS to the EMPLOYEE or COVERED SERVICE MEMBER: Please complete Section I before having Section II completed. The FMLA permits an employer to require that an employee submit a timely, complete, and sufficient certification to support a request for FMLA leave due to a serious injury or illness of a covered service member. If requested by the employer, your response is required to obtain or retain the benefit of FMLA-protected leave. Failure to do so may result in a denial of an employee's FMLA request. The employer must give an employee at least 15 calendar days to return this form to the employer.

SECTION II: For Completion by a UNITED STATES DEPARTMENT OF DEFENSE ("DOD") HEALTH CARE PROVIDER or a HEALTH CARE PROVIDER who is either: (1) a United States Department of Veterans Affairs ("VA") health care provider; (2) a DOD TRICARE network authorized private health care provider; or (3) a DOD non-network TRICARE authorized private health care provider INSTRUCTIONS to the HEALTH CARE PROVIDER: The employee listed on Page 2 has requested leave under the FMLA to care for a family member who is a member of the Regular Armed Forces, the National Guard, or the Reserves who is undergoing medical treatment, recuperation, or therapy, is otherwise in outpatient status, or is otherwise on the temporary disability retired list for a serious injury or illness. For purposes of FMLA leave, a serious injury or illness is one that was incurred in the line of duty on active duty that may render the service member medically unfit to perform the duties of his or her office, grade, rank, or rating.

A complete and sufficient certification to support a request for FMLA leave due to a covered service member's serious injury or illness includes written documentation confirming that the covered service member's injury or illness was incurred in the line of duty on active duty and that the covered service member is undergoing treatment for such injury or illness by a health care provider listed above. Answer, fully and completely, all applicable parts. Several questions seek a response as to the frequency or duration of a condition, treatment, etc. Your answer should be your best estimate based upon your medical knowledge, experience, and examination of the patient. Be as specific as you can; terms such as "lifetime," "unknown," or "indeterminate" may not be sufficient to determine FMLA coverage. Limit your responses to the condition for which the employee is seeking leave.

SECTION I: For Completion by the EMPLOYEE and/or the COVERED SERVICE MEMBER for whom the Employee Is Requesting Leave: (This section must be completed first before any of the below sections can be completed by a health care provider.)

Part A: EMPLOYEE INFORMATION

Name and Address of Employer (this is the employer of the employee requesting leave to care for covered service member):

_____

Name of Employee Requesting Leave to Care for Covered Service member:

_____

First Middle Last

Name of Covered Service member (for whom employee is requesting leave to care):

_____

First Middle Last

Relationship of Employee to Covered Service member Requesting Leave to Care:
☐Spouse ☐Parent ☐Son ☐Daughter ☐Next of Kin

Part B: COVERED SERVICE MEMBER INFORMATION

(1) Is the Covered Service member a Current Member of the Regular Armed Forces, the National Guard or Reserves? ☐Yes ☐No

If yes, please provide the covered service member's military branch, rank and unit currently assigned to:

_____

Is the covered service member assigned to a military medical treatment facility as an outpatient or to a unit established for the purpose of providing command and control of members of the Armed Forces receiving medical care as outpatients (such as a medical hold or warrior transition unit)? ☐Yes ☐No If yes, please provide the name of the name of the medical treatment facility or unit:_____

(2) Is the Covered Service member on the Temporary Disability Retired List (TDRL)?
☐Yes ☐No

Part C: CARE TO BE PROVIDED TO THE COVERED SERVICE MEMBER

Describe the Care to be provided to the Covered Service member and an Estimate of the Leave Needed to Provide the Care:

_____

_____

SECTION II: For Completion by a United States Department of Defense ("DOD") Health Care Provider or a Health Care Provider who is either: (1) a United States Department of Veterans Affairs ("VA") health care provider; (2) a DOD TRICARE network authorized private health care provider; or (3) a DOD non-network TRICARE authorized private health care provider. If you are unable to make certain of the military-related determinations contained below in Part B, you are permitted to rely upon determinations from an authorized DOD representative (such as a DOD recovery care coordinator). (Please ensure that Section I above has been completed before completing this section.) Please be sure to sign the form on the last page.

Part A: HEALTH CARE PROVIDER INFORMATION

Health Care Provider's Name and Business Address:

_____

Type of Practice/Medical Specialty:_____

Please state whether you are either: (1) a DOD health care provider; (2) a VA health care provider; (3) a DOD TRICARE network authorized private health care provider; or (4) a DOD non-network TRICARE authorized private health care provider:

_____

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

PART B: MEDICAL STATUS

(1) Covered Service member's medical condition is classified as (Check One of the Appropriate Boxes):

□ **(VSI) Very Seriously Ill/Injured** – Illness/Injury is of such a severity that life is imminently endangered. Family members are requested at bedside immediately. (Please note this is an internal DOD casualty assistance designation used by DOD healthcare providers.)

□ **(SI) Seriously Ill/Injured** – Illness/injury is of such severity that there is cause for immediate concern, but there is no imminent danger to life. Family members are requested at bedside. (Please note this is an internal DOD casualty assistance designation used by DOD healthcare providers.)

□ **OTHER Ill/Injured** – a serious injury or illness that may render the service member medically unfit to perform the duties of the member's office, grade, rank, or rating.

□ **NONE OF THE ABOVE** (Note to Employee: If this box is checked, you may still be eligible to take leave to care for a covered family member with a "serious health condition" under § 825.113 of the FMLA. If such leave is requested, you may be required to complete DOL FORM WH-380 or an employer-provided form seeking the same information.)

(2) Was the condition for which the Covered Service member is being treated incurred in line of duty on active duty in the armed forces? □Yes □No

(3) Approximate date condition commenced:_____

(4) Probable duration of condition and/or need for care: _____

(5) Is the covered service member undergoing medical treatment, recuperation, or therapy? □Yes □No If yes, please describe medical treatment, recuperation or therapy:

_____

_____

PART C: COVERED SERVICE MEMBER'S NEED FOR CARE BY FAMILY MEMBER

(1) Will the covered service member need care for a single continuous period of time, including any time for treatment and recovery? □Yes □No
If yes, estimate the beginning and ending dates for this period of time:

_____

(2) Will the covered service member require periodic follow-up treatment appointments? □Yes □No If yes, estimate the treatment schedule:

_____

(3) Is there a medical necessity for the covered service member to have periodic care for these follow-up treatment appointments? □Yes □No

(4) Is there a medical necessity for the covered service member to have periodic care for other than scheduled follow-up treatment appointments (e.g., episodic flare-ups of medical condition)? □Yes □No If yes, please estimate the frequency and duration of the periodic care:

_____

_____

_____

_____

_____

Signature of Health Care Provider: _____ Date: _____