**FMLA FORM 5**

# FAMILY AND MEDICAL LEAVE ACT (FMLA) - CERTIFICATION OF FAMILY RELATIONSHIP

College: Hostos Community College

In order to approve your request for FMLA leave, CUNY is requesting information and documentation of your relationship to the individual for whom you will be caring or for whom you are otherwise taking leave.

Under the FMLA, family members include:

- Parents (biological, adoptive, step or foster father or mother, or any other individual who stood in *loco parentis* to the employee when the employee was a son or daughter)
- Spouse
- Child (biological, adoptive, step or foster children, legal wards, or a child of a person standing in *loco parentis* of the employee). *Note:* Child must be either under age 18, or age 18 or older and "incapable of self-care because of a mental or physical disability" at the time that FMLA leave is to commence.

Family members do not include in-laws, grandparents, siblings and other extended family members.

For purposes of military caregiver leave under FMLA, next of kin of a covered service member means the nearest blood relative other than the covered service member's spouse, parent, son or daughter in the following order of priority:

- blood relatives who have been granted legal custody of the covered service member by court decree or statutory provisions
- brothers and sisters
- grandparents
- aunts and uncles
- first cousins

**UNLESS** the covered service member has specifically designated in writing another blood relative (the employee) as his or her nearest blood relative for purposes of military caregiver leave under the FMLA.

**Employee Information:**

Name _____ Empl. ID _____

Contract Title _____ Department _____

**Reason for requesting leave *(Check appropriate box)***

- ☐ To care for my family member with serious health condition
- ☐ To care for a seriously injured or ill servicemember or veteran related to employee
- ☐ Family member is on or has been called to active duty in the military

**Family Member's Name** _____ **Relationship to Employee** _____

## EMPLOYEE CERTIFICATION

I certify that the family member for whom I need to provide care for a serious health condition under the FMLA is a covered family member as defined.

Signature _____ Date _____

***CUNY RESERVES THE RIGHT TO REQUEST SUPPORTING DOCUMENTS SUCH AS BIRTH CERTIFICATES, MARRIAGE CERTIFICATES AND RELEVANT COURT DOCUMENTS.***

**RECEIVED BY (This form must be signed by the Director of Human Resources or Designee)**

Name _____ Signature _____

Date _____