CUNY The City University of New York

FMLA FORM 1

FAMILY AND MEDICAL LEAVE ACT (FMLA) - REQUEST FORM

College: 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 FMLA leave, this form must be submitted as early as practicable, preferably no fewer than 30 days in advance of the start of your leave. **CUNY reserves the right to deny or postpone leave for failure to give appropriate notice.**

Employee Information:

Name _____ Empl. ID _____

Contract Title _____ Department _____

Supervisor Name _____ Phone _____ Email _____

Contact information while on leave: Home Phone _____ Cell Phone _____ Email _____

Reason for requesting leave *(Check appropriate box)*

- ☐ My own serious health condition *(Attach Certification of Healthcare Provider)*
- ☐ Birth of my child; to care for my newborn child — Date of birth _____
- ☐ Placement of child with me for adoption or foster care — Date of placement _____

Attach appropriate documents

- ☐ To care for my family member with serious health condition *(Attach Certification of Healthcare Provider & Certification of Family Relationship Form)*
- ☐ To care for a seriously injured or ill servicemember or veteran related to employee *(Attach Certification of Healthcare Provider & Certification of Family Relationship Form)*
- ☐ Family member is on or has been called to active duty in the military *(Attach Certification of Qualifying Exigency & Certification of Family Relationship Form)*

Period of Leave

- ☐ I request CONTINUOUS FMLA LEAVE, starting Date _____ and ending Date _____
- ☐ I request INTERMITTENT FMLA LEAVE, starting Date _____
- ☐ I request REDUCED WORK SCHEDULE FMLA LEAVE, starting Date _____ and ending Date _____

Number of hours/week _____

Anticipated schedule of absence must be discussed with supervisor.
For Intermittent or Reduced Work Schedule, appropriate documents must be attached.

EMPLOYEE STATEMENT OF UNDERSTANDING

I am aware of and understand the following:

1. If the leave is for my own serious health condition or to care for a family member with a serious health condition, I must return a completed medical certification form to the Office of Human Resources within 15 days of the College's request, or as soon as practicable. Failure to do so may result in my leave being delayed until I provide this documentation; if the certification is not clear, the College can contact the Healthcare Provider for clarification.
2. Following a leave for my own serious illness, I may be required to present a fitness for duty certification to the Office of Human Resources.
3. My health benefits will continue during my leave and I am expected to continue to pay my share of health insurance premiums, if any.
4. 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 Office of Human Resources, prior to the conclusion of my FMLA leave.
5. If I fail to return to work upon the conclusion of this approved leave, I may be subject to disciplinary proceedings or other action in accordance with CUNY policies and applicable collective bargaining agreements.

Signature _____ Date _____

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

Name _____ Signature _____

Date _____