

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 related to employee
- F. Family member is on or has been called to active duty in the military.

Name/Relationship of Family Member _____ . 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.

Signature of Employee

Date: _____

Received by: _____
Human Resources Director/Personnel Officer

Date: _____

Certification of Health Care Provider for
Family Member's Serious Health Condition
(Family and Medical Leave Act)

THE CITY UNIVERSITY OF NEW YORK

Baruch 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 protections because of a need for leave to care for a covered family member with a serious health condition to submit a medical certification issued by the health care provider of the covered family member. Please complete Section I before giving this form to your employee. 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. Employers must generally maintain records and documents relating to medical certifications, recertifications, or medical histories of employees' family members, created for FMLA purposes as confidential medical records in separate files/records from the usual personnel files.

Employer contact: _____

SECTION II: For Completion by the EMPLOYEE

INSTRUCTIONS to the EMPLOYEE: Please complete Section II before giving this form to your family member or his/her medical provider. The FMLA permits an employer to require that you submit a timely, complete, and sufficient medical certification to support a request for FMLA leave to care for a covered family member with a serious health condition. If requested by your employer, your response is required to obtain or retain the benefit of FMLA protections. Failure to provide a complete and sufficient medical certification may result in a denial of your FMLA request. Your employer must give you at least 15 calendar days to return this form.

Your name: _____
 First Middle Last

Name of family member for whom you will provide care: _____
 First Middle Last

Relationship of family member to you: _____

If family member is your son or daughter, date of birth: _____

Describe care you will provide to your family member and estimate leave needed to provide care: _____

Employee Signature

Date

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SECTION III: For Completion by the HEALTH CARE PROVIDER

INSTRUCTIONS to the HEALTH CARE PROVIDER: The employee listed above has requested leave under the FMLA to care for your patient. Answer, fully and completely, all applicable parts below. 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 patient needs. Please be sure to sign the form on the last page.

Provider's name and business address: _____

Type of practice / Medical specialty: _____

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

PART A: MEDICAL FACTS

1. Approximate date condition commenced _____

Probable duration of condition: _____

Was the patient admitted for an overnight stay in a hospital, hospice, or residential medical care facility?
___No ___Yes. If so, dates of admission: _____

Date(s) you treated the patient for condition: _____

Will the patient need to have treatment visits at least twice per year due to the condition? ___No ___Yes.

Was medication, other than over-the-counter medication, prescribed? ___No ___Yes

Will the patient need to have treatment visits at least twice per year due to the condition? ___No ___Yes

Was the patient referred to other health care provider(s) for evaluation or treatment (e.g., physical therapist)?
___No ___Yes. If so, state the nature of such treatments and expected duration of treatment:

2. Is the medical condition pregnancy? ___No ___Yes. If so, expected delivery date: _____

3. Describe other relevant medical facts, if any, related to the condition for which the patients needs care (such medical facts may include symptoms, diagnosis, or any regimen of continuing treatment, such as the use of specialized equipment):

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PART B: AMOUNT OF CARE NEEDED: When answering these questions, keep in mind that your patient's need for care by the employee seeking leave may include assistance with basic medical, hygienic, nutritional, safety or transportation needs, or the provision of physical or psychological care:

4. Will the employee be incapacitated for a single continuous period of time, including any time for treatment and recovery? ___No ___Yes.

Estimate the beginning and ending dates for the period of incapacity: _____

Explain the care needed by the patient and why such care is medically necessary: _____

5. Will the patient require follow-up treatments, including any time for recovery? ___No ___Yes.

Estimate treatment schedule, if any, including the dates of any scheduled appointments and the time required for each appointment, including any recovery period:

Explain the care needed by the patient, and why such care is medically necessary: _____

_____hour(s) per day; _____days per week from _____through _____

6. Will the patient require care on an intermittent or reduced schedule basis, including any time for recovery? ___No ___Yes

Estimate the hours the patient needs care on an intermittent basis, if any:

_____hour(s) per day; _____days per week from _____through _____

Explain the care needed by the patient, and why such care is medically necessary: _____

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7. Will the condition cause episodic flare-ups periodically preventing the patient from participating in normal daily activities? ___No ___Yes

Based upon the patient's medical history and your knowledge of the medical condition, estimate the frequency of flare-ups and the duration of related incapacity that the patient may have over the next 6 months (e.g., 1 episode every 3 months lasting 1-2 days):

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

Duration: _____ hours or _____ day(s) per episode

Does the patient need care during these flare-ups? ___No ___Yes

Explain the care needed by the patient, and why such care is medically necessary: _____

ADDITIONAL INFORMATION: IDENTIFY QUESTION NUMBER WITH YOUR ADDITIONAL ANSWER.

Signature of Health Care Provider

Date