

TO: Employees Holding Full-time Tax-levy Appointments
FROM: Office of the Assistant Vice President for Human Resource Services
SUBJECT: FAMILY MEDICAL LEAVE ACT (FMLA)

As an employee of The City University of New York, you are eligible for consideration for leave under the Family Medical Leave Act (FMLA). This memorandum will assist you in understanding the University Regulations for requesting, receiving and returning from an FMLA leave.

Prior to the enactment of the Family Medical Leave Act, CUNY employees already had provisions in their collective bargaining agreements which covered several of the leave categories within the FMLA law; e.g., temporary disability and child care. When approved leaves are granted employees in accordance with University regulations, and are also permissible under FMLA, they shall be concurrently counted toward the annual maximum of 12 weeks of FMLA leave permitted within a twelve (12) month period. For purposes of tracking FMLA usage, the twelve (12) month period begins on the first day of approved FMLA leave.

Employees are eligible for FMLA leave if the employee has worked continuously at any CUNY college for at least twelve (12) months, and for at least 1,250 hours during the year preceding the leave.

The United States Department of Labor has determined that all full-time salaried employees, such as full-time faculty in institutions of higher education, who have worked for the employer for at least 12 months are presumed to have met the 1,250 hours of service requirement for FMLA eligibility.

Employees of the CUNY Research Foundation or any other separately incorporated employer affiliated with CUNY or a CUNY college are not CUNY employees and are not covered by these guidelines.

Questions concerning FMLA leave should be addressed to:

Instructional Staff	Ms. Denise Flanagan	x5137	1231 Boylan
Civil Service Staff	Ms. Judith Rieger	x5377	1219 Boylan

Family and Medical Leave Request Form

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.)

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.

Signature of Employee

Date: _____

Received by: _____
Human Resources Director/Personnel Officer

Date: _____

CUNY FMLA Certification of Health Care Provider

Please complete this form in its entirety. Print or type all information provided unless a signature is requested.

<p>Instructions for Employee/Patient</p> <ol style="list-style-type: none"> 1. Complete Section A. 2. Give form to your health care provider and request the provider to complete and return the form directly to you. 3. Bring the form to Human Resources no later than 15 days following the date you received the form. 	<p>Instructions for Health Care Provider</p> <ol style="list-style-type: none"> 1. Complete Sections B-D. 2. Return to employee/patient within two weeks of receipt of form. 3. If you have any questions, contact The Human Resources Office
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Section A: To Be Completed by the Employee

Name:	Department:	Phone Number: Office _____ Home _____
Supervisor's Name:	Supervisor's Title:	Supervisor's Phone Number:
Patient's Name (if different from above):	Relationship of Patient to Employee: <input type="checkbox"/> Self <input type="checkbox"/> Parent <input type="checkbox"/> Spouse <input type="checkbox"/> Domestic Partner <input type="checkbox"/> Dependent Child	
Employee Signature	Date:	

Section B: To Be Completed by Health Care Provider

The City University of New York fully complies with the Family and Medical Leave Act (FMLA) of 1993, which provides benefits and job protection for eligible employees facing their own "serious health condition" or that of a family member. Under FMLA, a serious health condition is defined as an illness, injury, impairment or physical or mental condition involving any one or more of the qualifying treatments and conditions cited below. The above-named employee is requesting a family and medical leave of absence for his/her own serious health condition or that of a family member. Kindly check all treatments/conditions that apply.

Hospital Care, Inpatient Care – This is defined as an overnight stay in a hospital, hospice, or residential medical care facility, including any period of incapacity or subsequent treatment in connection with or consequent to such inpatient care. (Note: Incapacity means inability to work, attend school or perform regular daily activities due to the serious health condition, associated treatment, or recovery from treatment/condition)

Absence Plus Treatment – A period of incapacity of more than three (3) consecutive calendar days (including any subsequent treatment or period of incapacity relating to the same condition) that also involves: 1) Treatment two or more times by a health care provider, by a nurse or physician's assistant under direct supervision of a health care provider, or by a provider of health care services (e.g., physical therapist) under orders of, or on referral by a health care provider; or 2) Treatment by a health care provider on at least one occasion which results in a regimen of continuing treatment under the supervision of the health care provider.

Pregnancy – Any period of incapacity due to pregnancy, or for prenatal care.

Chronic Conditions Requiring Treatments – For FMLA purposes, a Chronic condition 1) Requires periodic visits for treatment by a health care provider, or by a nurse or physician's assistant under direct supervision of a health care provider, 2) Continues over an extended period of time, including recurring episodes of a single underlying condition and: 3) May cause episodic rather than a continuing period of incapacity (e.g., asthma, diabetes or epilepsy.)

Permanent or Long-term Conditions Requiring Supervision – This condition is defined as a period of incapacity which is permanent or long because of a condition for which treatment may not be effective. The employee or family member must be under the continuing supervision of, but need not be receiving active treatment by a health care provider. Examples include Alzheimer's, a severe stroke, or the terminal stages of a disease.

Section B: (Continued)

Multiple Treatments for Non-Chronic Conditions – This situation is defined by any period of absence to receive multiple treatments by a health care provider or by a provider of health care services under orders of, or on referral by, a health care provider, either for restorative surgery after an accident or other injury, or for a condition that would likely result in a period of incapacity of more than three (3) consecutive calendar days in the absence of medical intervention or treatment, such as cancer (chemotherapy, or radiation), severe arthritis (physical therapy), and kidney disease (dialysis). This also includes any time off for a period of recovery from treatments.

Section C: To Be Completed by Health Care Provider

Describe the **medical facts of patient** supporting your certification that would help us understand how the patient's condition meets one of the "Serious Health Condition" categories you checked.

Indicate whether incapacity is episodic, periodic, or extended, and the approximate date the condition commenced.

If additional treatments or a regimen of treatments will be required (by you or under your supervision), please provide a general description of the regimen (e.g., prescription drugs, physical therapy requiring special equipment.)

If the employee will be absent from work on an intermittent or part-time basis, please provide the following:

Probable number of treatments _____ Interval between treatment _____

Dates of treatment if known _____ Period required for recovery if any _____

If FMLA leave is for a family member, explain whether the family member requires physical and/or psychological assistance or comfort from the employee.

What is the actual or estimated duration of any incapacity of employee or the family member?

Employee's return to work date:

Section D: To Be Completed by Health Care Provider

Health Care Provider's Name:

Type of Practice:

Address:

Phone Number:

Health Care Provider's Signature:

Date: