

THE CITY UNIVERSITY OF NEW YORK
CONFIDENTIAL APPLICATION FOR LEAVE
Family Medical Leave Act of 1993

Any approved leave for illness granted under the University's temporary disability leave provisions which extends beyond 5 days will be counted as part of the employee's FMLA entitlement, if it qualifies. Authorized absences for medical reasons, paid or unpaid, anticipated or unanticipated, which extend for more than 5 days will be counted as FMLA leave from the beginning of the absence. A notification of such absences must be made to the College HR Director.

ORAL NOTICE MAY PRECEDE WRITTEN NOTICE

FOR ANTICIPATED ABSENCE notice must be given when the absence is expected to continue, or has extended beyond three calendar days;

FOR ANTICIPATED ABSENCE this application should be submitted at least thirty days before leave is to begin. The College HR Director may request the submission of medical certification. If required to submit medical certification, must be presented within fifteen days of request. Failure to comply in a timely manner may result in the leave being delayed or denied.

To Be Completed By Applicant: Date ____ ____ ____

Name _____ Title/Rank _____

Department _____ Phone Number ____ ____ ____

I hereby apply for leave under the FMLA Act of 1993 for the period:

Dates: From ____ ____ ____ To ____ ____ ____

Signature of Applicant _____ Date ____ ____ ____

Indicate Permissible Reason for taking the leave: Reason Number _____

If leave is for other than your own medical illness, indicate:

Name of family member _____ Relationship _____

Identity documents on file, which establish relationship, or attach documentation establishing relationship. (Do not attach originals).

Explanation of reason for which leave is requested _____

For anticipated leave you will be required, where necessary, to submit medical certification from a health care provider within fifteen days on the University form.

I understand that:

- Recertification of Medical Documentation may be required.
- A fitness for duty certification will be required prior to return to work where the FMLA leave is a result of the employee's health condition.
- I may be reinstated to the same or a similar position.
- If I fail to return to work immediately upon conclusion of the FMLA leave, I shall be treated as having voluntarily terminated my employment. If, under current University leave policies, I am eligible to lengthen this leave, I will submit the appropriate documents prior to the conclusion of my FMLA leave.

The University will recover any employee premiums or payments made for the employee by the University while the employee is on unpaid leave.

Signature of Applicant _____ Date ____ ____ ____

Approved by _____ Date ____ ____ ____

College HR Director

Fmlappli.rkoIV 3/3/94

THE CITY UNIVERSITY OF NEW YORK MEDICAL CERTIFICATION FORM

Certification of Physician or Practitioner (Family and Medical Leave Act of 1993)

1. Employee's Name	2. Patient's Name (If other than employee)
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3. Diagnosis

4. Date Condition Commenced	5. Probable duration of condition
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6. Regimen of treatment to be prescribed (indicate number of visits, general nature and duration of treatment, including referrals to other provider of health services. Include schedule of visits or treatment. If it is medically necessary for the employee to be off work on an intermittent basis or to work less than the employee's normal schedule of hours per day or days per week.)

a) By Physical or Practitioner

b) By another provider of health services, if referred by Physician or Practitioner

If this certification relates to care for the employee's seriously-ill family member, skip items 7, 8, and 9 and proceed to items 13 thru 20 on reverse side. Otherwise, continue below.

Check Yes or No in the boxes below, as appropriate

- 7. Is inpatient hospitalization of the employee required? Yes ___ No ___
- 8. Is employee able to perform work of any kind? (If "No", skip item 9) Yes ___ No ___
- 9. Is employee able to perform the functions of employee's position? (Answer after reviewing statement from employer of essential functions of employee's position, or if none provided, after discussing with employee) Yes ___ No ___

10. Signature of Physician or Practitioner	11. Date / /	12. Type of Practice (Field of Specialization, if any)
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**U.S. DEPARTMENT OF LABOR
Employment Standards Administration
Wage and Hour Division**

Form WH-380 – June 1993

For certification relating to care for the employee's seriously-ill family member, complete items 13 thru 17 below as they apply to the family member and proceed to item 20.

13. Is Inpatient hospitalization of the family member (patient) required? Yes ___ No ___

14. Does (or will) the patient require assistance for basic medical, hygiene, nutritional needs, safety or transportation? Yes ___ No ___

15. After review of the employee's signed statement (See item 17 below), is the employee's presence necessary or would it be beneficial for the care of the patient? (This may include psychological comfort.) Yes ___ No ___

16. Estimate the period of time that care is needed or that the employee's presence would be beneficial.

Item 17 is to be completed by the employee needing family leave

17. When Family Leave is needed to care for a seriously-ill family member, the employee shall state the care he or she will provide and an estimate of the time period during which this care will be provided, including a schedule if leave is to be taken intermittently or on a reduced leave schedule.

18. Employee Signature		19. Date / /
20. Signature of Physician or Practitioner	21. Date / /	22. Type of Practice (Field of Specialization, if any)