FMLA FORM 1

The City University of New York

FAMILY AND MEDICAL LEAVE ACT (FMLA) - REQUEST FORM

College: Brooklyn 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 ____

FMLA FORM- 3 A

The City University of New York

FAMILY AND MEDICAL LEAVE ACT (FMLA)
CERTIFICATION OF HEALTH CARE PROVIDER FOR EMPLOYEE'S SERIOUS HEALTH CONDITION

Section 1: TO BE COMPLETED BY EMPLOYER

College: Brooklyn College   Address: 2900 Bedford Avenue

City: Brooklyn   State: NY   Zip Code: 11210   Tel.: ______   FAX: ______

Name of Employee ______   Empl. ID ______   Department ______

Contract Title ______   ☐ ***Job description attached***   Regular Work Schedule ______

Essential Job Functions
(If job description is not attached) ______

Section II: INSTRUCTIONS TO EMPLOYEE

FMLA permits CUNY to require that you submit a timely, complete, and sufficient medical certification to support a request for FMLA leave due to your own serious health condition. If requested by CUNY, 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 denial of your FMLA request.

CUNY gives you at least 15 calendar days to return this form.

This form must be returned by ______

Section III: INSTRUCTIONS TO HEALTH CARE PROVIDER

The employee listed above has requested leave under the FMLA. Answer fully and completely all applicable parts.
- 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 employee is seeking care.
- Do not provide information about genetic tests, genetic services, or the manifestation of disease or disorder in the employee's family members.

PLEASE PRINT CLEARLY OR TYPE. SIGN THE FORM ON THE LAST PAGE (PAGE 4).

Health Care Provider's Name ______________________________

Telephone ______________ FAX ______________

Address ______________________________

City ______________ State ______ Zip Code ______ Country ______________

Type of Practice /Medical Speciality:

FAMILY AND MEDICAL LEAVE ACT (FMLA)
CERTIFICATION OF HEALTH CARE PROVIDER FOR EMPLOYEE'S SERIOUS HEALTH CONDITION

PART A: MEDICAL FACTS

Approximate date condition commenced ____________________ Probable duration of condition ____________________

Answer as applicable

Was the patient admitted for an overnight stay in a hospital, hospice, or residential medical care facility? ☐ Yes ☐ No

If yes, dates of admission From ____________ To ____________

Dates you treated the patient for a condition ____

Will the patient need to have treatment visits at least twice per year due to the condition? ☐ Yes ☐ No

Was medication, other than over-the-counter medication, prescribed? ☐ Yes ☐ No

Was the patient referred to other health care provider(s) for evaluation or treatment (e.g., physical therapist)? ☐ Yes ☐ No

If yes, state the nature of such treatments and expected duration of treatment:

Is the medical condition pregnancy? ☐ Yes ☐ No If yes, expected date of delivery ____________________

Use the information provided by the Employer in Section 1 to answer this question. If the employer fails to provide a list of the employee's essential functions or a job description, answer these questions based upon the employee's own description of his/her job.

Is the employee unable to perform any of his/her job functions due to the condition? ☐ Yes ☐ No

If yes, identify the job functions the employee is unable to perform:

Describe other relevant medical facts, if any, related to the condition for which the employee seeks leave (such medical facts may include symptoms, diagnosis, or any regimen of continuing treatment, such as the use of specialized equipment):

FAMILY AND MEDICAL LEAVE ACT (FMLA)
CERTIFICATION OF HEALTH CARE PROVIDER FOR EMPLOYEE'S SERIOUS HEALTH CONDITION

PART B: AMOUNT OF LEAVE NEEDED

Will the employee be incapacitated for a single continuous period of time due to his/her medical condition, including any time for treatment and recovery? ☐ Yes ☐ No

If yes, estimate the beginning and end dates for the period of incapacity: From ____________ To ____________

Will the employee need to attend follow-up treatment appointments or work part-time or on a reduced schedule because of the employee's medical condition? ☐ Yes ☐ No

If yes, are the treatments or the reduced number of hours of work medically necessary? ☐ Yes ☐ No

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

Estimate the part-time or reduced work schedule the employee needs, if any: Hour(s) per day ____________ Days per week ____________

From ____________ To ____________

Will the condition cause episodic flare-ups periodically preventing the employee from performing his/her job functions? ☐ Yes ☐ No

Is it medically necessary for the employee to be absent from work during the flare-ups? ☐ Yes ☐ No

If yes, explain

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., episode every 3 months lasting 1-2 days):

Frequency No. of times per week ____________ No. of times per month ____________

Duration No. of hours per episode ____________ No. of day(s) per episode ____________

FAMILY AND MEDICAL LEAVE ACT (FMLA)
CERTIFICATION OF HEALTH CARE PROVIDER FOR EMPLOYEE'S SERIOUS HEALTH CONDITION

ADDITIONAL INFORMATION:

IDENTIFY QUESTION NUMBER WITH YOUR ADDITIONAL ANSWER:

PRINT NAME OF HEALTH CARE PROVIDER ______________________

SIGNATURE OF HEALTH CARE PROVIDER ______________________

LICENSE # ______________________

DATE ______________________

The City University of New York

FMLA FORM - 6

FITNESS FOR DUTY CERTIFICATION

College: Brooklyn College

An employee on FMLA Medical Leave of Absence because of his/her own serious medical condition must present this certification to the Human Resources Department prior to or on the day he/she returns to work.

Supervisors are advised to forward any forms submitted directly to them to the Human Resources Department.

An employee may not work without this certification. If you are on unpaid leave, Human Resources will place you back on the payroll ONLY upon receipt of this form.

Employee Information:

Name ____________ Empl. ID ____________

Contract Title ____________ Department ____________

Contact information while on leave Home Phone ____________ Cell Phone ____________ Email ____________

To: Health Care Provider

The employee noted above began a period of medical care leave for his /her own serious health condition on Date ____________

As a condition to return to work, the employee must have a health care provider certify that the employee is medically fit to resume his/her job duties.

Date employee may return to work ____________

☐ Employee may return to work with full, unrestricted duty

☐ Employee may return to work with modified duty Explain ____________

If the employee is being released to modified duty, please complete the following:

Estimated date when employee will be able to return to full, unrestricted duty ____________

Date of next medical evaluation of the employee ____________

HEALTH CARE PROVIDER'S CERTIFICATION

I certify that the above facts are true and correct.

Signature ____________ Date ____________

Print Name ____________ Phone Number ____________

Address ____________

City ____________ State ____ Zip Code ____________

Type of Practice ____________ License Number ____________

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

Signature ____________ Date ____________