CUNY The City University of New York

FMLA FORM 1

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 _____

CUNY The City University of New York

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

FMLA FORM-3 B

Section 1: TO BE COMPLETED BY EMPLOYER

College: Brooklyn College | Address: | City: | State: | Zip Code: | Tel.: | FAX:

Name of Employee: | Empl. ID: | Department:

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 to care for a covered family member with a serious health condition. If requested by CUNY, your response is required to obtain or retain the benefits of FMLA protections. Failure to provide a complete and sufficient medical certification may result in denial of your FMLA request.

Please complete this section and attach the CERTIFICATE OF FAMILY RELATIONSHIP FORM before giving this form to your family member or his/her Health Care Provider.

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

This form must be returned by

CERTIFICATE OF FAMILY RELATIONSHIP FORM MUST BE ATTACHED

Name of family member for whom you will provide care

Describe care to be provided by you

Estimate leave needed

Section III: INSTRUCTIONS TO 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.
- 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 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 _____ Tel.: _____ FAX _____

Address _____

City _____ State ____ Zip Code _____ Country _____

Type of Practice / Medical Speciality

FAMILY AND MEDICAL LEAVE ACT (FMLA)
CERTIFICATION OF HEALTH CARE PROVIDER FOR FAMILY MEMBER'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 Date _____ To Date _____

Dates you treated the patient for 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 _____

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):

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.

Will the patient 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 date _____ To date _____

During this time, will the patient need care? ☐ Yes ☐ No

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

Will the patient require follow-up treatments, including any time for recovery? ☐ 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:

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

PART B: AMOUNT OF CARE NEEDED *(continued)*

Will the patient require care on an intermittent or reduced schedule basis, including any time for recovery? ☐ Yes ☐ No

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

Hour(s) per day _____ Days per week _____

From date _____ To date _____

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

Will the condition cause episodic flare-ups periodically preventing the patient from participating in normal daily activities? ☐ Yes ☐ No

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., one 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 _____

Does the patient need care during these flare-ups? ☐ Yes ☐ No

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

ADDITIONAL INFORMATION:

IDENTIFY QUESTION NUMBER WITH YOUR ADDITIONAL ANSWER

PRINT NAME OF HEALTH CARE PROVIDER _____

SIGNATURE OF HEALTH CARE PROVIDER _____

LICENSE # _____ **DATE** _____

FMLA FORM 5

FAMILY AND MEDICAL LEAVE ACT (FMLA) - CERTIFICATION OF FAMILY RELATIONSHIP

College: Brooklyn College

In order to approve your request for FMLA leave, CUNY is requesting information and documentation of your relationship to the individual for whom you will be caring or for whom you are otherwise taking leave.
Under the FMLA, family members include:
- Parents (biological, adoptive, step or foster father or mother, or any other individual who stood in *loco parentis* to the employee when the employee was a son or daughter)
- Spouse
- Child (biological, adoptive, step or foster children, legal wards, or a child of a person standing in *loco parentis* of the employee). *Note:* Child must be either under age 18, or age 18 or older and "incapable of self-care because of a mental or physical disability" at the time that FMLA leave is to commence.

Family members do not include in-laws, grandparents, siblings and other extended family members.

For purposes of military caregiver leave under FMLA, next of kin of a covered service member means the nearest blood relative other than the covered service member's spouse, parent, son or daughter in the following order of priority:
- blood relatives who have been granted legal custody of the covered service member by court decree or statutory provisions
- brothers and sisters
- grandparents
- aunts and uncles
- first cousins

UNLESS the covered service member has specifically designated in writing another blood relative (the employee) as his or her nearest blood relative for purposes of military caregiver leave under the FMLA.

Employee Information:

Name _____ Empl. ID _____

Contract Title _____ Department _____

Reason for requesting leave *(Check appropriate box)*

☐ To care for my family member with serious health condition

☐ To care for a seriously injured or ill servicemember or veteran related to employee

☐ Family member is on or has been called to active duty in the military

Family Member's Name _____ **Relationship to Employee** _____

EMPLOYEE CERTIFICATION

I certify that the family member for whom I need to provide care for a serious health condition under the FMLA is a covered family member as defined.

Signature _____ Date _____

CUNY RESERVES THE RIGHT TO REQUEST SUPPORTING DOCUMENTS SUCH AS BIRTH CERTIFICATES, MARRIAGE CERTIFICATES AND RELEVANT COURT DOCUMENTS.

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

Name _____ Signature _____

Date _____