Family and Medical Leave Request Form ***THE CITY UNIVERSITY OF NEW YORK***

Medgar Evers 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 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.

_____ Date: _____
Signature of Employee

Received by:_____ Date:_____
Human Resources Director/Personnel Officer