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| **Instructions for requesting family and medical leave:**1. **Employee:** Complete Part 1 of this form and submit to supervisor a minimum of 30 days prior to leave begin date (complete as soon as possible for unplanned leave); obtain Certification forms from Human Resources and return within 15 days of receipt.
2. **Supervisor**: Review request with employee, sign Part 2, and forward to HR.
3. **Human Resources:** employee and supervisor will be notified of leave/FMLA approval status after review of request and receipt of Certification paperwork. Contact Employee Benefits Coordinator at 673-3434 with any questions pertaining to family or medical leave, FMLA, or this form.
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| **Part 1: EMPLOYEE**  |
| **Last Name First Name**  | **Home Telephone Number**  |
| **Mailing Address City & State Zip Code** |
| **Department Unit: Shift:**❑ CSEA❑ UUP ❑ MC ❑PEF❑ APSU ❑ NYSCOPBA❑ 1st ❑ 2nd ❑ 3rd  |
| **LEAVE DETAILS:** *Complete the following sections, using COMMENTS box as indicated. Sign and date before giving to immediate supervisor.*  |
| **Type of Leave:** ❑ FMLA ❑ NYS Paid Family Leave (UUP and M/C Only) ❑ Paid Parental Leave ❑ Multiple- *explain in COMMENTS* |
|  ❑ NEW ❑EXTENSION | Leave **BEGIN** Date: | **REASON for LEAVE** *(Required Certification Forms will be sent by HR):* ❑ **Employee’s Personal Illness/Serious Health Condition**❑ **Care for a Family Member (Spouse, Child, Parent) with a Serious Health Condition** ❑ **Birth of Child** ❑ **Adoption/Foster Care Placement of Child** ❑ **Military Family Exigency**  ❑ **Military Family Caregiver Leave** |
| Expected **RETURN** to Work Date: |
|  **Accruals you will charge during leave:**❑ Sick ❑ Vacation ❑ Holiday Comp❑ Personal (CSEA only) ❑ Other - *explain* *in* *COMMENTS*❑ None/UNPAID leave - *explain* *in* *COMMENTS* |
| *If you answer YES to any of the following, explain in COMMENTS:* **a) Are you requesting intermittent leave** (absence taken in separate blocks of time due to a single illness or injury)**?** ❑ YES ❑ NO **b) Are you requesting a reduced or alternate work schedule** (based on medical need)? ❑ YES ❑ NO **c) Do you anticipate exhausting paid accruals during your leave?** ❑ YES ❑ NO  |
| **COMMENTS:** |
| **I understand:** * This form does not substitute for department-level time off request or call-in procedures, which must continue to be followed;
* All required Certification forms must be returned to HR within 15 days of receipt;
* During **paid** leave (using accruals), benefit premiums will continue to be deducted from my paycheck; for **unpaid** leave, information on continuing benefit premium payments will be mailed to me by NYS Civil Service after the Benefits Division is notified of my unpaid leave status;
* For leave due to my own medical need, documentation clearing me to work must be submitted to HR PRIOR to returning to work; and
* I am responsible for notifying Human Resources and my Supervisor of any changes to information on this form or the status of my leave.
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| **Employee Signature**:  | **Date**:  |
| **Part 2: SUPERVISOR**  |
| **I understand:*** Signing below acknowledges receipt and review of this leave request; and
* This form does not constitute approval of leave or FMLA and does not substitute for Department-level time off request or call-in procedures.
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| **Supervisor Name**:  |  **Signature:**  | **Date**:  |