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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. | | | | | | |
| **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. | | | | | | |
| **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. | | | | | | |
| **Supervisor Name**: | | **Signature:** | | | | **Date**: |