What is FMLA?
FMLA is the abbreviation for the Family and Medical Leave Act of 1993. FMLA is a Federal Law that provides eligible employees with up to twelve (12) work weeks of leave (continuous or intermittent) during any 12-month period for one or more of the following reasons:

- Birth and care of the employee's child, within one year of birth;
- Placement of a child for adoption or foster care with the employee, within one year of the placement;
- Care of an immediate family member (spouse, child, parent) who has a serious health condition;
- For the employee's own serious health condition that makes the employee unable to perform the essential functions of his or her job;
- Qualifying exigency arising out of the fact that the employee’s spouse, child, or parent is on active duty or has been notified of an impending call or order to active duty in the U.S. National Guard or Reserves.

Military Caregiver Leave:
FMLA also provides eligible employees with up to twenty-six (26) weeks to care for a covered service member with a serious injury or illness if the employee is the spouse, child, parent or next of kin of the service member.

Eligibility:
Employees are eligible for FMLA leave when they have met the following criteria:
1. The employee has worked for CUNY for the last 12 months and,
2. The employee has worked at least 1,250 hours during the 12 months immediately preceding the FMLA leave.

Documentation:
All requests for FMLA leave will require accompanying documentation/certification from a licensed medical provider.

Paid vs. Unpaid Leave:
When the FMLA is used for the employee’s own illness or pregnancy, the employee may use his/her sick leave, annual leave, or unscheduled holiday balances to cover leave. If an employee has no leave accruals banked, s/he may still be approved for FMLA leave, though it may be unpaid. Please contact the Office of Human Resources to obtain your sick, annual leave, and unscheduled holiday balances.

When the FMLA is used to cover absence due to a family member’s illness, the employee may use up to three (3) days of sick leave, annual leave or unscheduled holidays to cover the leave.

Requirements for FMLA:
When the FMLA is for the employee:
When the need for leave is foreseeable, an employee must give the employer at least a thirty (30) days’ notice, or as much notice as is practicable. When the leave is not foreseeable, the employee must provide notice as soon as possible under the particular circumstances. If the request for FMLA leave is approved, Human Resources will send a letter to the employee and his/her supervisor to confirm the leave.

When the FMLA is needed to care for a sick family member:
The attached medical certification should be completed by the sick family member’s doctor and submitted to the Office of Human Resources as soon as possible.
PART II
(TO BE COMPLETED BY THE EMPLOYEE)

SECTION A: EMPLOYEE INFORMATION

1. Name of Employee Applying for Leave           2. Name of Patient if other than Employee

____________________________________  ______________________________________

3. Employee’s Signature/Date               4. Employee’s Email Address/Contact Number

____________________________________  ______________________________________

SECTION B: REASON FOR FMLA REQUEST—PLEASE CHECK ONE

___ Birth and care of the employee’s child, within one year of birth;

___ Placement of a child for adoption or foster care with the employee, within one year of the placement;

___ For the employee's own serious health condition that makes the employee unable to perform the essential functions of his or her job;

___ Care of an immediate family member (spouse, child, parent) who has a serious health condition;

___ Qualifying need arising out of the fact that the employee’s spouse, child, or parent is on active duty or has been notified of an impending call or order to active duty in the U.S. National Guard or Reserves;

___ To care for a covered service member with a serious injury or illness if the employee is the spouse, child, parent or next of kin of the service member.

SECTION C: DURATION AND FREQUENCY OF LEAVE

The type of FMLA leave being requested is for the following frequency (please check one):

___ Continuous   or

___ Intermittent: Frequency (Please state how often employee will need to be absent from work) __________________________

___ Reduced work schedule

Please indicate the anticipated start and end dates below:

(Anticipated) Start date of leave or reduced schedule _______________________

(Anticipated) End date of leave or reduced schedule _______________________

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PART III: CERTIFICATION OF HEALTHCARE PROVIDER  
(TO BE COMPLETED BY HEALTH PROVIDER)  
SECTION D – COMPLETE IF REQUESTED LEAVE IS TO COVER EMPLOYEE’S CONDITION

1. Page 5 describes what is meant by a “serious health condition” under the Family and Medical Leave Act. Does the patient’s condition qualify under any of the categories described? If so, please circle the appropriate category.

(1) (2) (3) (4) (5) (6) , or None of the above

2. Describe the medical facts which support your certification, including a brief statement as to how the medical facts meet the criteria of one of these categories:

3. State the approximate date the condition commenced, and the probable duration of the condition (and also the probable duration of the patient’s present incapacity if different):

4. Will be it necessary for the employee to take work only intermittently or to work on a less than full schedule as a result of the condition (including for treatment)?

5. If patient will be absent from work or other daily activities because of treatment on an intermittent or part-time basis, also provide whether additional treatments will be required and an estimate of the probable number and intervals between such treatments, actual or estimated dates and duration of treatment and period required for recovery if any:

6. If a regimen of continuing treatment by the patient is required under your supervision, provide a general description of such regimen (e.g., prescription drugs, physical therapy requiring special equipment.):

7. If the condition is a chronic condition or pregnancy, state whether the patient is presently incapacitated and the likely duration and frequency of episodes of incapacity:

8. If the employee does not have a chronic condition, but s/he is presently incapacitated please state the likely duration of incapacity:

9. If the employee is not incapacitated, but needs to be absent from work because of the his/her medical condition (including absences due to pregnancy or a chronic condition), state whether the employee is unable to perform work of any kind:

10. If any of these treatments will be provided by another provider of health services (e.g., physical therapist), please state the nature of the treatments:
SECTION E - COMPLETE IF REQUESTED LEAVE IS TO COVER SOMEONE OTHER THAN EMPLOYEE

1. Page 5 describes what is meant by a “serious health condition” under the Family and Medical Leave Act. Does the patient’s condition qualify under any of the categories described? If so, please check the appropriate category.

(1) (2) (3) (4) (5) (6) , or None of the above

2. If leave is required to care for a family member of the employee with a serious health condition, please explain generally what such care will entail:

3. State the approximate date the condition commenced, and the probable duration of the condition (and also the probable duration of the patient’s present incapacity, if different):

4. Will it be necessary for the employee to take work only intermittently or to work on a less than full schedule in order to provide care to the patient?

5. If the patient will need care only intermittently or on a part-time basis, please indicate the probable duration of this need and the frequency of intervals for which care will be required:

6. If a regimen of continuing treatment by the patient is required under your supervision, provide a general description of such regimen (e.g., prescription drugs, physical therapy requiring special equipment):

7. If additional treatments will be required for the condition, provide an estimate of the probable number of such treatments:

8. If any of these treatments will be provided by another provider of health services (e.g., physical therapist), please state the nature of the treatments:

Print of Healthcare Provider/License Number ____________________________
Signature of Healthcare Provider ____________________________

Type of Practice ____________________________________________
Address ____________________________________________

Contact Number(s) ____________________________
Date ____________________________
A. **“Serious Health Condition”** means an illness, injury impairment, physical or mental condition that involves one of the following:

1. **Hospital Care**

   **Inpatient Care** (i.e., an overnight stay) in a hospital, hospice, or residential medical care facility, including any period of incapacity or subsequent treatment in connection with or consequent to such inpatient care.

2. **Absence Plus Treatment**

   (a.) A period of incapacity of more than three (3) consecutive calendar days (including any subsequent treatment or period of incapacity relating to the same condition), that also involves:

   (1) **Treatment two (2) or more times** by a health care provider, or by a nurse or physician’s assistant under the direct supervision of a health care provider, or by a provider of health care services (e.g., physical therapist) under the supervision or referral by a health care provider; or

   (2) Treatment by a health care provider on at least one (1) occasion which results in a regimen of continued treatment under the supervision of the health care provider.

3. **Pregnancy**

   Any period of incapacity due to pregnancy or for prenatal care.

4. **Chronic Conditions Requiring Treatments**

   A chronic condition which:

   (1) Requires periodic visits for treatment by a healthcare provider, or by a nurse or physician’s assistant under direct supervision of a health care provider:

   (2) Continues over an extended period of time (including recurring episodes of a single underlying condition); and

   (3) May cause episodic rather than a continuing period of incapacity (e.g., asthma, diabetes, epilepsy, etc.)

5. **Permanent/Long-term Conditions Requiring Supervision**

   A period of incapacity which is permanent or long-term due to a condition for which treatment may be not be effective. The employee or family member must be under the continuing supervision of a health care provider, but need not be receiving active treatment by, a health care provider. Examples include Alzheimer’s, a severe stroke, or the terminal stages of a disease.

6. **Multiple Treatments (Non-Chronic Conditions)**

   Any period of absence to receive multiple treatments (including any period of recovery therefrom) by a healthcare provider or by a provider of health care services under orders of, or on referral by, a health care provider, either for restorative surgery after an accident or other injury, or for a condition that would likely result in a period of incapacity of more than three (3) consecutive calendar days in the absence of medical intervention or treatment, such as cancer (chemotherapy, radiation, etc.) severe arthritis (physical therapy), and kidney disease (dialysis).