BOROUGH OF MANHATTAN COMMUNITY COLLEGE
THE CITY UNIVERSITY OF NEW YORK
COLLEGE
CONFIDENTIAL APPLICATION FOR LEAVE
Family Medical Leave Act of 1993

Covered employees are eligible for Family Medical Leave if they have worked for the college for a total of 12 months AND for at least 1,250 hours during the year preceding the effective date of the leave. The leave year for determining usage of the 12 week entitlement shall be the Academic Year: September 1 through August 31.

**Permissible Reasons For Taking FMLA Leave:**

1. For birth of a son or daughter, and to care for the newborn child
2. For placement with the employee of a son or daughter for adoption or foster care
3. To care for the employee's spouse, domestic partner, son, daughter, or parent with a serious health condition, and
4. Because of a serious health condition that makes the employee unable to perform the essential functions of his/her job.

Any approved leave for illness granted under the University's temporary disability leave provisions which extends beyond five days will be counted as part of the employee's FMLA entitlement, if it qualifies. Authorized absences for medical reasons, paid or unpaid, anticipated or unanticipated, which extend for more than FIVE days will be counted as FMLA leave from the beginning of the absence. A notification of such absences must be made to the College Personnel Director. However, such notification whether oral or written does not amend or change the continuance of any and all internal college, Board of Trustees, CUNY Rules and Regulations, or contractual notification requirements currently in effect.

For anticipated absences a written request to cover such absences must be submitted to the college personnel director at least thirty days before the leave is to begin. However, such written application does not amend or change the continuance of any and all internal college, Board of Trustees, CUNY Rules and Regulations, or contractual notification requirements currently in effect. For unanticipated absences the College Personnel Director must be notified when the absence is expected to continue, or has extended beyond three calendar days.

In instances where oral notification is given first, it must be followed up by a written request. Failure to comply or submission of an incomplete request in a timely manner may result in the leave being delayed or denied.

Prior to granting the employee authorization to use leave accruals for a possible FMLA qualifying event, the College Personnel Director must review and approve all documentation in support of leave request to determine: (1) if your request is for a qualifying event, (2) if all required documentation has been submitted and approved, (3) if your usage of the Family Medical Leave allocation during the current University defined leave year permits this leave time, and (4) if your leave, dependent on permissible accrual usage, will be taken with or without pay. Upon approval of leave by College Personnel Director, paid leave accruals must be used prior to granting of unpaid leave. Both paid and unpaid FMLA leave are counted collectively as part of the maximum twelve (12) week entitlement within the September 1 – August 31 FMLA leave year.
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disability leave provisions which extends beyond five days will be counted as
part of the employee's FMLA entitlement, if it qualifies. Authorized absences
for medical reasons, paid or unpaid, anticipated or unanticipated, which extend
more than FIVE days will be counted as FMLA leave from the beginning of the
absence. A notification of such absences must be made to the College Personnel
Director. (See reverse side of this form for synopsis of policies and practices
governing leave.)

ORAL NOTICE MAY PRECEDE WRITTEN NOTICE

FOR UNANTICIPATED ABSENCE notice must be given when the absence is expected to
continue, or has extended beyond three calendar days;
FOR ANTICIPATED ABSENCES this application should be submitted at least thirty
days before leave is to begin. The College Personnel Director may request the
submission of medical certification. If required to submit medical
certification, it must be presented within fifteen days of request. Failure to
comply in a timely manner may result in the leave being delayed or denied.

To Be Completed By Applicant:

Name ____________________________
Department ____________________________
Title/Rank ____________________________
Phone Number ____________________________

Date: ____________________________

I hereby apply for leave under the FMLA Act of 1993 for the period:

Dates: From: ____________________________ To: ____________________________

Signature of Applicant ____________________________ Date: ______________________

Indicate Permissible Reason for taking the leave (from categories on reverse side
of form):

Reason Number ____________________________

If leave is for other than your own medical illness, indicate:

Name of family member ____________________________ Relationship ____________________________

Identify documents on file which establish relationship, or attach documentation
establishing relationship (do not attach originals)

Explanation of reason for which leave is requested

For anticipated leave you will be required, where necessary, to submit medical
certification within fifteen days from a health care provider on the University
form.

I understand that:

Recertification of Medical Documentation may be required
A fitness for duty certification will be required prior to return to work
where the FMLA leave is a result of the employee's health condition.
I may be reinstated to the same or a similar position
If I fail to return to work immediately upon conclusion of the FMLA leave,
I shall be treated as having voluntarily terminated my employment. If, under
current University leave policies, I am eligible to lengthen this leave, I will
submit the appropriate documents prior to the conclusion of my FMLA leave.
The University will recover any employee premiums or payments made for the
employee by the University while the employee is on unpaid leave.

Signature of Applicant ____________________________ Date ____________________________

Approved by ____________________________ Date ____________________________

College Personnel Director
A “Serious Health Condition” means an illness, injury, impairment, or physical or medical 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\(^2\) or subsequent treatment in connection with or consequent to such inpatient care.

2. Absence Plus Treatment

   (a) A period of incapacity\(^2\) of more than three consecutive calendar days (including any subsequent treatment or period of incapacity\(^2\) relating to the same condition), that also involves:

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

   (2) Treatment by a health care provider on at least one occasion which results in a regimen of continuing treatment\(^4\) 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 health care 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\(^2\) (e.g., asthma, diabetes, epilepsy, etc.).

5. Permanent/Long-term Conditions Requiring Supervision

   A period of incapacity\(^2\) which is permanent or long-term due to a condition for which treatment may not be effective. The employee or family member must be under the continuing supervision or, but need not be receiving active treatment by, a health care provider. Example include Alzheimer’s, a severe stroke, or the terminal stages of a disease.

\(^1\)Treatment includes examinations to determine if a serious health condition exists and evaluations of the condition. Treatment does not include routine physical examinations, eye examinations, or dental examinations.

\(^2\)A regimen of continuing treatment includes, for example, a course of prescription medication (e.g., an antibiotic) or therapy requiring special equipment to resolve or alleviate the health condition. A regimen of treatment does not include the taking of over-the-counter medications such as aspirin, antihistamines, or salves; or bed-rest, drinking fluids, exercise, and other similar activities that can be initiated without a visit to a health care provider.

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

Any period of absence to receive **multiple treatments** (including any period of recovery therefrom) by a health care 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 consecutive calendar days in the absence of medical intervention or treatment*, such as cancer (chemotherapy, radiation, etc.), severe arthritis (physical therapy), kidney disease (dialysis).
Certification of Physician or Practitioner (Optional Form WH-380)

Certification of Health Care Provider
(Family and Medical Leave Act of 1993)

1. Employee’s Name: ______________________

2. Patient’s Name (if different from employee): ______________________

3. The attached sheet describes what is meant by a "serious health condition" under the Family and Medical Leave Act. Does the patient’s condition1 qualify under any of the categories described? If so, please check the applicable category.

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

4. 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:

5. a. State the approximate date the condition commenced, and the probable duration of the condition (and also the probable duration of the patient’s present incapacity2 if different):

   b. Will it be 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 described in Item 6 below)? ______

   If yes, give the probable duration:

   c. If the condition is a chronic condition (condition #4) or pregnancy, state whether the patient is presently incapacitated2 and the like duration and frequency of episodes of incapacity2:

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

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

   b. 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:

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1Here and elsewhere on this form, the information sought relates only to the condition for which the employee is taking FMLA leave.

2"Incapacity," for purpose of FMLA, is defined to mean inability to work, attend school or perform other regular daily activities due to the serious health condition, treatment therefor, or recovery therefrom.
c. 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. a. If medical leave is required for the employee's absence from work because of the employee's own condition (including absences due to pregnancy or a chronic condition), is the employee unable to perform work of any kind? ______

   b. If able to perform some work, is the employee unable to perform any one or more of the essential functions of the employee's job (the employee or the employer should supply you with information about the essential job functions)? ______ If yes, please list the essential functions the employee is unable to perform:

   c. If neither a. nor b. applies, is it necessary for the employee to be absent from work for treatment? ______

8. a. If leave is required to care for a family member of the employee with a serious health condition, does the patient require assistance for basic medical or personal needs or safety, or for transportation? ______

   b. If no, would the employee's presence to provide psychological comfort be beneficial to the patient or assist in the patient's recovery? ______

   c. If the patient will need care only intermittently or on a part-time basis, please indicate the probable duration of this need:

   ____________________________  ____________________________
   (Signature of Health Care Provider)  (Type of Practice)
   ____________________________  ____________________________
   (Address)  (Telephone number)

To be completed by the employee needing family leave to care for a family member:

State the care you will provide and an estimate of the period during which care will be provided, including a schedule if leave is to be taken intermittently or if it will be necessary for you to work less than a full schedule:

   ____________________________  ____________________________
   (Employee signature)  (date)

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