CUNY The City University of New York

FMLA FORM 1

FAMILY AND MEDICAL LEAVE ACT (FMLA) - REQUEST FORM

College: York 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 FMLA leave, this form must be submitted as early as practicable, preferably no fewer than 30 days in advance of the start of your leave. **CUNY reserves the right to deny or postpone leave for failure to give appropriate notice.**

Employee Information:

Name: Marie Valentine | Empl. ID:

Contract Title: | Department:

Supervisor Name: | Phone: | Email:

Contact information while on leave | Home Phone: | Cell Phone: | Email:

Reason for requesting leave *(Check appropriate box)*

- ☐ My own serious health condition *(Attach Certification of Healthcare Provider)*
- ☐ Birth of my child; to care for my newborn child — Date of birth:
- ☐ Placement of child with me for adoption or foster care — Date of placement:

Attach appropriate documents

- ☐ To care for my family member with serious health condition *(Attach Certification of Healthcare Provider & Certification of Family Relationship Form)*
- ☐ To care for a seriously injured or ill servicemember or veteran related to employee *(Attach Certification of Healthcare Provider & Certification of Family Relationship Form)*
- ☐ Family member is on or has been called to active duty in the military *(Attach Certification of Qualifying Exigency & Certification of Family Relationship Form)*

Period of Leave

- ☐ I request CONTINUOUS FMLA LEAVE, starting Date: and ending Date:
- ☑ I request INTERMITTENT FMLA LEAVE, starting Date:
- ☐ I request REDUCED WORK SCHEDULE FMLA LEAVE, starting Date: and ending Date:

Number of hours/week:

Anticipated schedule of absence must be discussed with supervisor.
For Intermittent or Reduced Work Schedule, appropriate documents must be attached.

EMPLOYEE STATEMENT OF UNDERSTANDING

I am aware of and understand the following:

1. If the leave is for my own serious health condition or to care for a family member with a serious health condition, I must return a completed medical certification form to the Office of Human Resources within 15 days of the College's request, or as soon as practicable. Failure to do so may result in my leave being delayed until I provide this documentation; if the certification is not clear, the College can contact the Healthcare Provider for clarification.
2. Following a leave for my own serious illness, I may be required to present a fitness for duty certification to the Office of Human Resources.
3. My health benefits will continue during my leave and I am expected to continue to pay my share of health insurance premiums, if any.
4. 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 Office of Human Resources, prior to the conclusion of my FMLA leave.
5. If I fail to return to work upon the conclusion of this approved leave, I may be subject to disciplinary proceedings or other action in accordance with CUNY policies and applicable collective bargaining agreements.

Signature _____ Date _____

RECEIVED BY (This form must be signed by the Director of Human Resources or Designee)

Name: | Signature:

Date:

FMLA FORM- 3 A

The City University of New York

FAMILY AND MEDICAL LEAVE ACT (FMLA)
CERTIFICATION OF HEALTH CARE PROVIDER FOR EMPLOYEE'S SERIOUS HEALTH CONDITION

Section 1: TO BE COMPLETED BY EMPLOYER

College: York College | Address: 94-20 Guy R. Brewer Blvd.

City: Jamaica | State: NY | Zip Code: 11451 | Tel.: 7182622135 | FAX:

Name of Employee: Marie Valentine | Empl. ID: | Department:

Contract Title: | ☐ *Job description attached* | Regular Work Schedule:

Essential Job Functions
(If job description is not attached):

Section II: INSTRUCTIONS TO EMPLOYEE

FMLA permits CUNY to require that you submit a timely, complete, and sufficient medical certification to support a request for FMLA leave due to your own serious health condition. If requested by CUNY, your response is required to obtain or retain the benefit of FMLA protections. Failure to provide a complete and sufficient medical certification may result in denial of your FMLA request.

CUNY gives you at least 15 calendar days to return this form.

This form must be returned by:

Section III: INSTRUCTIONS TO HEALTH CARE PROVIDER

The employee listed above has requested leave under the FMLA. Answer fully and completely all applicable parts.

- Several questions seek a response as to the frequency or duration of a condition, treatment, etc. Your answer should be your best estimate based upon your medical knowledge, experience, and examination of the patient.
- Be as specific as you can; terms such as "lifetime", "unknown", or "indeterminate" may not be sufficient to determine FMLA coverage.
- Limit your responses to the condition for which the employee is seeking care.
- Do not provide information about genetic tests, genetic services, or the manifestation of disease or disorder in the employee's family members.

PLEASE PRINT CLEARLY OR TYPE. SIGN THE FORM ON THE LAST PAGE (PAGE 4).

Health Care Provider's Name: Kelly Gilgeours, MD

Telephone: 718-712-8511 | FAX: 718-527-5624

Address: 117-06 225 St.

City: Cambria Heights | State: NY | Zip Code: 11411 | Country: US

Type of Practice /Medical Speciality: private / pediatrics

FAMILY AND MEDICAL LEAVE ACT (FMLA)
CERTIFICATION OF HEALTH CARE PROVIDER FOR EMPLOYEE'S SERIOUS HEALTH CONDITION

PART A: MEDICAL FACTS

Approximate date condition commenced 5|2021 Probable duration of condition guarded

Answer as applicable

Was the patient admitted for an overnight stay in a hospital, hospice, or residential medical care facility? ☐ Yes ☑ No

If yes, dates of admission From _____ To _____

Dates you treated the patient for a condition 1|7|22, 3|11|22, 3|23|22, 4|5|22, 4|18|22, 4|29|22, 5|10|22, 5|31|22, 6|6|22, 6|7|22, 10|5|22

Will the patient need to have treatment visits at least twice per year due to the condition? ☑ Yes ☐ No

Was medication, other than over-the-counter medication, prescribed? ☑ Yes ☐ No

Was the patient referred to other health care provider(s) for evaluation or treatment (e.g., physical therapist)? ☑ Yes ☐ No

If yes, state the nature of such treatments and expected duration of treatment:

ENT - evaluation and treatment

Is the medical condition pregnancy? ☐ Yes ☑ No If yes, expected date of delivery _____

Use the information provided by the Employer in Section 1 to answer this question. If the employer fails to provide a list of the employee's essential functions or a job description, answer these questions based upon the employee's own description of his/her job.

Is the employee unable to perform any of his/her job functions due to the condition? ☐ Yes ☐ No

If yes, identify the job functions the employee is unable to perform:

Describe other relevant medical facts, if any, related to the condition for which the employee seeks leave (such medical facts may include symptoms, diagnosis, or any regimen of continuing treatment, such as the use of specialized equipment):

Jaasiel is around school age children and exposed to normal childhood illnesses. When he is sick he has symptoms of cough & wheezing. He is treated with Albuterol nebulizer solution every 4-8 hours as needed. He needs to be monitored for respiratory distress and follow up with his pediatrician within 48-72 hours.

FAMILY AND MEDICAL LEAVE ACT (FMLA)
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PART B: AMOUNT OF LEAVE NEEDED

Will the employee be incapacitated for a single continuous period of time due to his/her medical condition, including any time for treatment and recovery? ☐ Yes ☑ No

If yes, estimate the beginning and end dates for the period of incapacity: From _____ To _____

Will the employee need to attend follow-up treatment appointments or work part-time or on a reduced schedule because of the employee's medical condition? ~~☐ Yes~~ ☑ No

If yes, are the treatments or the reduced number of hours of work medically necessary? ☐ Yes ☐ No

Estimate treatment schedule, if any including the dates of any scheduled appointments and the time required for each appointment, including any recovery period:

fever reducer every 4-6 hrs as needed
Cough suppressants every 6 hrs. as needed
Albuterol nebulizer treatments every 4-8 hrs as needed

Estimate the part-time or reduced work schedule the employee needs, if any: Hour(s) per day _____ Days per week _____

From _____ To _____

Will the condition cause episodic flare-ups periodically preventing the employee from performing his/her job functions? ☑ Yes ☐ No

Is it medically necessary for the employee to be absent from work during the flare-ups? ☑ Yes ☐ No

If yes, explain

See part A

Based upon the patient's medical history and your knowledge of the medical condition, estimate the frequency of flare-ups and the duration of related incapacity that the patient may have over the next 6 months (e.g., episode every 3 months lasting 1-2 days):

Frequency No. of times per week 1 - 2 No. of times per month 3

Duration No. of hours per episode 12 No. of day(s) per episode 2 - 3

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CERTIFICATION OF HEALTH CARE PROVIDER FOR EMPLOYEE'S SERIOUS HEALTH CONDITION

ADDITIONAL INFORMATION:

IDENTIFY QUESTION NUMBER WITH YOUR ADDITIONAL ANSWER:

PRINT NAME OF HEALTH CARE PROVIDER Kelly Gilgeours, MD

SIGNATURE OF HEALTH CARE PROVIDER Kelly Gilgeours MD.

LICENSE # 303300

DATE 11/8/2022

CAMKIDS PEDIATRICS, P.C.
117-06 225TH ST, 1ST FL
CAMBRIA HEIGHTS, NY 11411
TEL:(718)712-8511
FAX(718)527-5624