



Form # 3

LEAVE REQUEST FORM

EMPLOYEE NAME: _____

DOH: _____

DEPARTMENT: _____

CC: _____

SOCIAL SECURITY #: _____

TYPE OF LEAVE

☐ Family Medical Leave for:

☒ The birth of a child or placement of a child with you for adoption or foster care; or

☐ A serious health condition that makes you unable to perform the essential functions for your job; or

☐ A serious health condition affecting your

☐ spouse/domestic partner,

☐ child, or

☐ parent for which you are needed to provide care

☐ Military Family Medical Leave

☐ Military Caregiver Leave

☐ Qualifying Exigency Leave

☐ Child Care (if selecting birth of a child or placement of a child with you for adoption or foster care, this leave must be selected)

☐ Donated

☐ Military – Active Military Duty Leave

☐ Sick Leave Half Pay

☐ Suspension

☐ Other Paid Leave _____

☐ Absent Status

☐ Civil Service Leave From Title

Effective Leave Date: _____

Expected Return Date: _____

Employee Signature: _____

Date: _____

Supervisor: ☐ Approved ☐ Denied

Signature: _____

Date: _____

Department Head: ☐ Approved ☐ Denied

Signature: _____

Date: _____

Human Resources: ☐ Approved ☐ Denied

Signature: _____

Date: _____

Reason for Denial: _____

Note: If leave request is denied, please indicate why in the space provided.

Note: If "Family Medical Leave" is selected, you must complete form on the 2nd page.

Note: If FMLA Leave is being taken on intermittent basis, the 2nd page must be completed on a bi-weekly basis until leave entitlement is exhausted.

Note: Medical Certification for Illness and/or Birth/Adoption Certificate must accompany application

FMLA LEAVE CALCULATIONS

(1) Units of Days Used for Leave

(2) # of Work Days

(3) Total Units for Leave (1 x 2)

AMOUNT OF PAID LEAVE TO BE CHARGED (Use same units as above)

Sick Leave

Vacation Leave

Personal Leave

Floating Holiday

Blood Day

Non-FLSA Compensatory Leave

Other: _____

(4) TOTAL PAID LEAVE TO BE USED FOR FAMILY LEAVE

UNPAID UNITS OF FAMILY LEAVE – See above: (3) minus (4)

Leave Dates Requested

Enter the leave dates the employee is requesting. Mark all paid leave dates with the appropriate code (see below) and all unpaid leave dates with the code "U".

Sick – S	Vacation – V	Personal – P	Floating – F	Blood Day – B	Comp – C
1 _____		21 _____		41 _____	
2 _____		22 _____		42 _____	
3 _____		23 _____		43 _____	
4 _____		24 _____		44 _____	
5 _____		25 _____		45 _____	
6 _____		26 _____		46 _____	
7 _____		27 _____		47 _____	
8 _____		28 _____		48 _____	
9 _____		29 _____		49 _____	
10 _____		30 _____		50 _____	
11 _____		31 _____		51 _____	
12 _____		32 _____		52 _____	
13 _____		33 _____		53 _____	
14 _____		34 _____		54 _____	
15 _____		35 _____		55 _____	
16 _____		36 _____		56 _____	
17 _____		37 _____		57 _____	
18 _____		38 _____		58 _____	
19 _____		39 _____		59 _____	
20 _____		40 _____		60 _____	

Note: Compensatory days may be used for a leave, but compensatory time earned pursuant to the Fair Labor Standards Act (FLSA) does not run concurrently with FMLA leave. Compensatory days accrued pursuant to the FLSA do not count towards FMLA entitlements.



Certification of Health Care Provider

1) Employees Name: _____

Department: _____

Employee ID number: _____

2) Patient's Name (If different from employee): _____

3) Serious Health Condition.

i) Page 4 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? (Please check the appropriate line below.)

(a) Inpatient Care

(b) Continuing Treatment

(c) Chronic Condition Requiring Treatment

(d) Permanent/Long-Term Condition Requiring Supervision

(e) Non- Chronic Condition Requiring Multiple Treatments

(f) Pregnancy or Prenatal Care

(g) Treatment for Substance Abuse

4) Information about the condition.

i) 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):

ii) What type of leave will the employee need to take:

(1) Full time leave? _____

(2) Part time leave? _____

(3) Intermittent leave? _____

- 5) If the employee is taking intermittent leave or will be working less than a full schedule as a result of the condition (including for treatment described in Item E below)? If yes, give the probable duration of the leave and a statement as to the frequency of the leave and duration of each absence?

- i) If the condition is a **chronic condition** (condition (c)) or **pregnancy**, state whether the patient is presently incapacitated and the likely duration and frequency of **episodes of incapacity**

6) Information About the Treatment.

- i) 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 of and interval between such treatments, actual or estimated dates of treatment if known, and period required for recovery if any:

- ii) 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:

- iii) 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) **Abilities at Work.**

i) **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?**

ii) **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)?**

(a) **If yes, please let the essential functions the employee is unable to perform:**

iii) **If neither 1 nor 2 applies, is it necessary for the employee to be absent from work for treatment?**

8) **Care for a Family Member.**

i) **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?**

ii) **Would the employee's presence to provide psychological comfort be beneficial to the patient or assist in the patient's recovery?**

iii) **If the patient will need care only intermittently or on a part-time basis, please indicate the probably duration of this need:**

SERIOUS HEALTH CONDITION: A "serious health condition" is defined in 29 CFR 825.114 to 825.117 as an illness, injury, impairment or physical or mental condition that includes any of the following:

- a) **Inpatient Care:** Inpatient care means an overnight stay in a hospital, hospice, or residential medical facility, including any period of incapacity or subsequent treatment in connection with or consequent to such inpatient care.
- b) **Continuing Treatment:** A period of incapacity of more than three consecutive calendar days, including any subsequent treatment or period of incapacity relating to the same condition, that also involves:
 - i) *Treatment two or more times within 30 days of the first day of incapacity 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 the orders of, or on referral by, a health care provider; or*
 - ii) *Treatment by a health care provider on at least one occasion which results in a regimen of continuing treatment under the supervision of the health care provider.*
 - iii) The requirement for treatment by a health care provider means an in person visit to a health care provider. The first (or only) in-person treatment visit must take place within seven days of the first day of incapacity.
- c) **Chronic Conditions Requiring Treatments:** A chronic condition which:
 - (i) 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; and
 - (ii) Continues over an extended period of time (including recurring episodes of a single underlying condition); and
 - (iii) May cause episodic rather than continuing periods of incapacity (e.g. asthma, diabetes, epilepsy, etc.)
- d) **Permanent/Long-Term Conditions Requiring Supervision:** A period of incapacity 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 of, but need not be receiving active treatment from, a health care provider. Examples include Alzheimer's, a severe stroke, or the terminal stages of a disease.
- e) **Multiple Treatments (Non-Chronic Conditions):** Any period of absence to receive multiple treatments (including any period of recovery there from) 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 for treatment, such as cancer (*chemotherapy, radiation, etc.*), severe arthritis (*physical therapy*), kidney disease (*dialysis*).
- f) **Pregnancy or Prenatal Care:** The mother is entitled to FMLA leave for incapacity due to pregnancy, for prenatal care, or for her own serious health condition following the birth of a child. The mother is entitled to leave for incapacity due to pregnancy even though she does not receive treatment from a health care provider during the absence, and even if the absence does not last for more than three consecutive calendar days.
- g) **Non- Qualifying Conditions:** Routine physical exams, eye or dental exams, cosmetic treatments, cold, flu and earaches, upset stomach etc. that require only brief treatment and recovery are *not "serious health conditions" unless inpatient hospital care is required or complications develop.*

- h) **Treatment for substance abuse** may be a serious health condition and is covered only if the conditions of FMLA are met. Leave may only be taken for treatment of substance abuse by a health care provider or by a provider of health care services on referral by a health care provider. Absence due to an employee's use of the substance, rather than for treatment, does not qualify for FMLA leave.

Signature of Health Care Provider

Date

Address of Health Care Provider
(Stamp Accepted)

Address 1

Type of Practice

Address 2

Street

City, Town, Zip Code

Telephone Number



**POLICE DEPARTMENT
COUNTY OF NASSAU, NEW YORK**

INTERNAL CORRESPONDENCE

DATE: MONTH DATE, 2021 **SNCC NO:**

TO: Commanding Officer, Personnel and Accounting (Through Official Channels)

FROM: Police Officer NAME, Serial Number NUMBER, Shield Number NUMBER, Second Precinct

SUBJECT: REQUEST FAMILY MEDICAL LEAVE

1. Attached is a request for Family Medical Leave from Police Officer NAME.
2. I have worked more than the minimally required hours during the twelve months preceding the leave.
3. I was hired MONTH DAY YEAR and have NUMBER years of service in the Department.

NAME
Police Officer

ENDORSED	/	DATE
DEPUTY C.O. C.O. DIV C.O. DEPUTY OFFICE CHIEF OFFICE CHIEF		

FAMILY AND MEDICAL LEAVE - FMLA

Department Administrative Order 21-021

Members can request to take a leave of absence through the FMLA for the following reasons:

1. For the birth of a child, and to bond with a child within one year of birth.
 2. To bond/take care of an adoptive or foster child, within one year of placement.
 3. To take care of a spouse, child, or a parent (not an in-law) because of a serious health condition.
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1. Members must write a letter of request to the Commissioner of Police – to be approved by the Commissioner and MAO (Medical Administration Office ext 7410)
 2. Family medical leave requests are up to 12 weeks long, consecutive or to be broken up throughout the year.
 3. Members who take family leave are to use their own time to continue to get paid. After all time is exhausted, members will be put in a No-pay status. Members can only use sick time if it is for their own sickness.
 4. Medical benefits will be maintained during a 12 - week period whether you are using time or in a "No pay" status.
 5. To qualify for FMLA you must have worked for the county for 12 months and worked 1250 hours, any time off you have taken would be deducted from hours worked.

FMLA DOES NOT MEAN – that you are getting 12 weeks off for free and getting paid the whole time. If you want to get paid during your leave – you must use your time.

What FMLA means is that you will not lose your job by taking a leave of absence, that you can take this time without following the rules for taking time off. (vacation %, MOA's etc...)

SUPPLEMENTAL LEAVE / PAY

If a member **runs out of time** for health reasons or personal problems, they can request supplemental leave/pay. Supplemental pay is a member can collect ½ pay. When a member is out on supplemental leave – the members health insurance stays in effect.

Just like FMLA Members must write a letter of request to the Commissioner of Police – to be approved by the Commissioner and MAO (Medical Administration Office ext 7410).