



CITY OF NEW HAVEN
**APPLICATION for INTERMITTENT
FAMILY AND MEDICAL LEAVE**



I. TO BE COMPLETED BY EMPLOYEE:

Employee Information

Name _____ Employee # _____

Address _____

City _____ State _____ Zip _____

Primary Phone # _____ Secondary Phone # _____

Primary E-mail Address _____

Department Employed _____ Union Affiliation _____

Job Title _____

____ I elect to use any outstanding vacation, personal, and sick hours during my leave

____ I do not elect to use any outstanding vacation, personal, and sick hours during my leave (unless otherwise required by the employees collective bargaining agreement)

Anticipated Start Date _____ Expected End Date _____

Employees have the right to take intermittent or reduced schedule FMLA leave, when medically necessary, care for a child, spouse, or parent who has a serious health condition, or for military family reasons. Intermittent FMLA may be requested for bonding with a newborn or newly placed child only if they and their employer agree. Reason for Leave (Explain) _____

Please read and initial next to each statement below:

____ I understand that a FMLA leave request is based on an employee's serious health condition or the serious health condition of an employee's spouse, child or parent must be accompanied by a verifying medical certification from a physician. In the case of intermittent leave or leave on a reduced leave schedule which is medically necessary, I, the employee, shall advise my employer, upon request, of the reasons why the intermittent/reduced leave schedule is necessary and of the schedule for treatment, if applicable.

____ I understand that:

- A certification is considered "incomplete" if one or more of the applicable entries on the form have not been completed.
- A certification is considered "insufficient" if the information provided is vague, unclear, or non-responsive.

_____I understand that I, the employee, and my Supervisor/ Department head shall attempt to work out a schedule which meets the employee's needs without unduly disrupting the employer's operations, subject to the approval of the health care provider.

_____I hereby authorize the City of New Haven, its employees and agents to contact my physician to verify the medical necessity for my requested leave or for any other information concerning my requested family and medical leave.

_____I understand that my employer may request a second and third opinion if if the City has doubt as to the validity of the initial medical certification. I also understand that medical recertification may be requested every six months at my expense and may be requested more frequently if the circumstances of the original certification have changed. These scenarios include an increase in frequency of absences, if my employer has a reason to doubt the validity of the absence, such as a Friday/Monday absence pattern, or if my employee asks for an extension of the leave.

_____I understand that along with the recertification, my employer may provide the doctor with a list of absences to ensure the absences are consistent with the medical condition.

_____I understand that exceeding the approved number of intermittent FMLA hours may be treated as a resignation.

Employee's Signature _____ Date _____

II. TO BE COMPLETED BY DEPARTMENT HEAD OR COORDINATOR:

Employee's Hire Date with the City _____

Did employee use FMLA time in the last 12 months? Yes No

If yes, provide the dates used:

Department Head/Coordinator's Signature _____ Date _____

III. TO BE COMPLETED BY DIRECTOR OF HUMAN RESOURCES:

Check one: ☐ Leave Approved for: _____ Days/Weeks

☐ Leave Denied (explain): _____

Director's Signature _____ Date _____

IV. TO BE COMPLETED BY FMLA COMMITTEE IN CASE OF APPEAL:

Check one: ☐ Leave Approved for: _____ Days/Weeks

☐ Leave Denied (explain): _____

Committee's Signature _____ Date _____

Your Employee Rights Under the Family and Medical Leave Act

What is FMLA leave?

The Family and Medical Leave Act (FMLA) is a federal law that provides eligible employees with **job-protected leave** for qualifying family and medical reasons. The U.S. Department of Labor's Wage and Hour Division (WHD) enforces the FMLA for most employees.

Eligible employees can take **up to 12 workweeks** of FMLA leave in a 12-month period for:

- The birth, adoption or foster placement of a child with you,
- Your serious mental or physical health condition that makes you unable to work,
- To care for your spouse, child or parent with a serious mental or physical health condition, and
- Certain qualifying reasons related to the foreign deployment of your spouse, child or parent who is a military servicemember.

An eligible employee who is the spouse, child, parent or next of kin of a covered servicemember with a serious injury or illness **may take up to 26 workweeks** of FMLA leave in a single 12-month period to care for the servicemember.

You have the right to use FMLA leave in **one block of time**. When it is medically necessary or otherwise permitted, you may take FMLA leave **intermittently in separate blocks of time, or on a reduced schedule** by working less hours each day or week. Read Fact Sheet #28M(c) for more information.

FMLA leave is **not paid leave**, but you may choose, or be required by your employer, to use any employer-provided paid leave if your employer's paid leave policy covers the reason for which you need FMLA leave.

Am I eligible to take FMLA leave?

You are an **eligible employee** if **all** of the following apply:

- You work for a covered employer,
- You have worked for your employer at least 12 months,
- You have at least 1,250 hours of service for your employer during the 12 months before your leave, and
- Your employer has at least 50 employees within 75 miles of your work location.

Airline flight crew employees have different "hours of service" requirements.

You work for a **covered employer** if **one** of the following applies:

- You work for a private employer that had at least 50 employees during at least 20 workweeks in the current or previous calendar year,
- You work for an elementary or public or private secondary school, or
- You work for a public agency, such as a local, state or federal government agency. Most federal employees are covered by Title II of the FMLA, administered by the Office of Personnel Management.

How do I request FMLA leave?

Generally, **to request FMLA leave you must:**

- Follow your employer's normal policies for requesting leave,
- Give notice at least 30 days before your need for FMLA leave, or
- If advance notice is not possible, give notice as soon as possible.

You **do not have to share a medical diagnosis** but must provide enough information to your employer so they can determine whether the leave qualifies for FMLA protection. You **must also inform your employer if FMLA leave was previously taken** or approved for the same reason when requesting additional leave.

Your **employer may request certification** from a health care provider to verify medical leave and may request certification of a qualifying exigency.

The FMLA does not affect any federal or state law prohibiting discrimination or supersede any state or local law or collective bargaining agreement that provides greater family or medical leave rights.

State employees may be subject to certain limitations in pursuit of direct lawsuits regarding leave for their own serious health conditions. Most federal and certain congressional employees are also covered by the law but are subject to the jurisdiction of the U.S. Office of Personnel Management or Congress.

What does my employer need to do?

If you are eligible for FMLA leave, your **employer must:**

- Allow you to take job-protected time off work for a qualifying reason,
- Continue your group health plan coverage while you are on leave on the same basis as if you had not taken leave, and
- Allow you to return to the same job, or a virtually identical job with the same pay, benefits and other working conditions, including shift and location, at the end of your leave.

Your **employer cannot interfere with your FMLA rights** or threaten or punish you for exercising your rights under the law. For example, your employer cannot retaliate against you for requesting FMLA leave or cooperating with a WHD investigation.

After becoming aware that your need for leave is for a reason that may qualify under the FMLA, your **employer must confirm whether you are eligible** or not eligible for FMLA leave. If your employer determines that you are eligible, your **employer must notify you in writing:**

- About your FMLA rights and responsibilities, and
- How much of your requested leave, if any, will be FMLA-protected leave.

Where can I find more information?

Call **1-866-487-9243** or visit **dol.gov/fmla** to learn more.

If you believe your rights under the FMLA have been violated, you may file a complaint with WHD or file a private lawsuit against your employer in court. **Scan the QR code to learn about our WHD complaint process.**



WAGE AND HOUR DIVISION
UNITED STATES DEPARTMENT OF LABOR

SCAN ME

