CITY OF NEW HAVEN
APPLICATION for LEAVE OF ABSENCE
& 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 _____

Type of Leave Request

I am requesting the following type of Leave Of Absence:

☐ FMLA (non-intermittent) ☐ Medical ☐ Personal

Start Date of Anticipated Leave _____ Expected Date of Return _____

☐ 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)

Reason for Leave (Explain) _____

Please read and initial next to each statement below:

_____I understand that the City of New Haven will pay its portion of the cost of the employee's health, dental, life and disability insurance benefits, as applicable, while an employee is on LOA (excluding Civil Service Leaves). The employee must continue to pay their portion of the benefits, either by payroll deductions (if on paid leave), or by check (if on unpaid leave) which must be submitted to the Human Resource Department each pay period, unless other arrangements have been agreed upon by the employee and the Human Resources Department. The employee's coverage under the group health plan shall be under the same conditions as would have been provided if the employee had been continuously employed during the entire approved LOA period.

_____I understand that if I fail to pay my portion of the benefits for more than 30 days, the my benefits will be terminated and I will be offered Consolidated Omnibus Budget Reconciliation Act (COBRA) coverage to continue health and dental benefits.

_____I understand that every attempt will be made to restore me to my original position upon return from leave. If my original position is unavailable, I will be placed in an equivalent position with equivalent pay and benefits (unless otherwise required by my collective bargaining agreement).

_____I understand that a failure to return to work at the end of my leave period may be treated as a resignation.

For FMLA and Medical Requests:

_____I understand that as a condition of restoration from a FMLA or medical leave that I must provide my employer a written certification from my health care provider stating that I am able to resume working.

_____I understand that a FMLA or Medical leave request 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.

_____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 my employer may request medical recertification during the same leave year, no more often than every 30 days for a short-term condition or after six months for a longer-term condition, or sooner if, for example, the medical circumstances have changed significantly.

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

_____I understand that in the event that I fail to return from leave after the expiration of the FMLA or Medical leave period, that I will be liable for both mine and the City's share of the insurance premiums incurred during the leave, unless the reason that I don't return is due to the continuation of a serious health condition or of my family member or other circumstances beyond my control as set forth in 29 CFR 825.213. In such instances, medical certification may be required. The cost of the certification shall be my responsibility and I am not entitled to be paid for the time or travel costs spent in acquiring the certification. If my employer requests medical certification and I do not provide such certification in a timely manner (not to exceed 30 days absent exigent circumstances), or the reason for not returning to work does not meet the test of other circumstances beyond my control, the employer may recover 100% of the health benefit premiums it paid during the period of unpaid FMLA or Medical leave.

_____I understand that I may choose not to retain group health plan coverage during FMLA or Medical leave. However, when I return from leave, I am entitled to be reinstated on the same terms as prior to taking the leave, including family or dependent coverage, without any qualifying period, physical examination, exclusion of pre-existing conditions, etc.

Employee's Signature _____**Date** _____

II. TO BE COMPLETED BY DEPARTMENT HEAD OR COORDINATOR:

Department Head/Coordinator's Signature_____ Date_____

For Personal Leave Only (not FMLA/Medical Leave)

Approval of this leave will cause significant operational issues. Yes ☐ No ☐

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

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