Management Employee Medical Leave – FMLA

The following provides initial information for employees that need time off for their own medical conditions. If you have 12 months of NYPA service, at least 1,250 hours over the past 12 months, this absence may qualify under the Family Medical Leave Act (FMLA). If you qualify, you may take up to 12 weeks of unpaid job protected leave in a 12-month period. **You must contact HR Services or your site HR Representative to schedule a consultation to discuss your leave request. For White Plains/Albany, you may send your request to HR.Services@NYPA.gov with "Leave" in the subject line.**

Attached and listed below are the documents required to begin the leave process. These forms will be discussed with you during your leave consultation with a Benefits representative.

Leave Request Form

You must complete this form to initiate the leave process.

Healthcare Provider Certification

This form must be completed by you and your healthcare provider 30 days prior to the start of your leave or as soon as practicable.

Privacy Law Notification

This is a required notice under the Public Officers Law when collecting personal information about you for your Family and Medical Leave.

Below are links to the NYPA policies relating to leaves.

- E.P. 3.3 Family & Medical Leave Act (FMLA)
- EP 3.12 Time away from work
- E.P 2.1 Salary Administration

Return-to-Work Requirements

You are required to provide certification or a letter from your healthcare provider to return to work from medical leave. This certification must be provided **5 business days prior to your return**. You will not be permitted to return to work without this medical release.

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LEAVE REQUEST FORM – MANAGEMENT

EMPLOYEE INFORMATION	
Employee Name:	Employee Location:

REASON FOR LEAVE OF ABSENCE (check all that apply)

Family Medical Leave	**Paid Family Leave**
❑ Employee Medical Leave	❑ Baby Bonding
❑ Care for Family Member (FMLA)	❑ Care for Family Member (PFL)
❑ NYPA Parental Leave	❑ Service Member Care/ Exigency Leave
❑ Military Leave	❑ **Other**
❑ Service Member Care/ Exigency Leave	❑ Personal Leave not covered by any other options
❑ Employee Medical Leave(non-FMLA)	

LEAVE TIMEFRAME

1. I am requesting consecutive leave (2 weeks or longer) for the following dates:

   Beginning on (date): _____ Ending on (date): _____

2. I am requesting intermittent leave per the following schedule:
   (Intermittent leaves should have a set schedule)

PAY WHILE ON LEAVE (check all that apply)

Please apply the following option(s):

1. ❑ Employee Medical Leave
   - Sick Accruals until depleted then,
   - Use available accruals then,
     ❑ Accrued Vacation ❑ Floating Holiday
   - Salary Continuation @ 50%

2. ❑ NYPA Parental Leave/Salary Continuation (12 weeks at 100%)

3. ❑ Paid Family Leave (PFL) benefit only (administered by The Hartford)

4. ❑ Subsidize PFL with Sick ❑ Subsidize PFL with Vacation ❑ Subsidize PFL with Floating Holiday

5. Family Leave Accruals Only ❑ Sick ❑ Vacation ❑ Floating Holiday

6. ❑ Unpaid Leave

EMPLOYEE CERTIFICATION AND SIGNATURE

I understand I am responsible for the cost of my insurance benefits if on unpaid leave and authorize Human Resources to make up insurance premiums owed upon my return to work.

Signature: _____ Date: _____

Please provide a personal email where we can reach you while on leave.

Email:_____ Phone #_____

The employee above has notified me of their intent to take a leave of absence.

Manager's Signature:_____ Date:_____

Please return the completed form to HR.Services@nypa.gov

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Health Care Provider Medical Certification

Your patient has requested an Employee Medical Leave for a serious health condition requiring sufficient medical certification to support this leave. Please complete this form and return it via email: HR.Services@nypa.gov or fax to (914) 681-6222.

SECTION 1 - EMPLOYEE

Employee Name:_____ Employee Position:_____

Essential Job Functions:_____

_____

Job description (❑ is/ ❑ is not) attached

SECTION II – HEALTHCARE PROVIDER)

Provider Details

Provider Name: _____ Address: _____

Specialty: _____ Email: _____

EIN Number: _____ Phone: _____

License Number: _____ Fax: _____

Medical Information

Limit your response to the medical condition(s) for which the employee is seeking medical leave.

(1) What is the first date the employee will be unable to work due to this condition: _____

(2) Provide your **best estimate** of when the employee will be able to return to work (complete all that apply):

- Full capacity return date: _____
- Intermittent Leave or Reduced Work Schedule (*must include days per week/hours per day*):_____

  _____
- Other Accommodations or Restrictions (e.g., remote work, ergonomic modifications, physical limitations):

  _____

  _____

Health Care Provider Signature _____ **Date**_____

IMPORTANT NOTICES CONCERNING MEDICAL INFORMATION

Privacy Law Notification

SECTION 94(1)(d) OF THE NEW YORK PUBLIC OFFICERS LAW REQUIRES THIS NOTICE TO BE PROVIDED WHEN COLLECTING PERSONAL INFORMATION FROM APPLICANTS FOR FAMILYAND MEDICAL LEAVE.

This information is requested pursuant to the Family Medical Leave Act of 1993. The principal purpose for which the information is collected is for the approval of family or medical leave and the maintenance of employee records in Human Resources in accordance with Section 96(1) of the Personal Privacy Protection Law, particularly subdivisions (b), (e), and (1).

Failure to provide the requested information may result in a denial of an employee's request for family or medical leave.

This information will be maintained by the Vice President of Human Resources at the Power Authority of the State of New York located at 123 Main Street, White Plains, New York 10601 (914-681-6200), or when appropriate, at one of the various Authority facilities.

Genetic Information Nondiscrimination Act of 2008 (GINA)
Employee's Serious Health Condition and Family Member's Serious Health Condition

The Genetic Information Nondiscrimination Act of 2008 (GINA) prohibits the New York Power Authority and other entities covered by GINA Title II from requesting or requiring genetic information of an individual or family member of the individual, except as specifically allowed by this law. To comply with this law, we are asking that you not provide any genetic information when responding to this request for medical information. "Genetic Information" as defined by GINA includes an Individual's family medical history, the results of an individual's or family member's genetic tests, the fact that an individual or an individual's family member sought or received genetic services, and genetic information of a fetus carried by an individual or an individual's family member or an embryo lawfully held by an individual or family member receiving assistive reproductive services.

Please provide medical history information regarding your patient only to extent necessary to fully respond to all relevant items and/or the attached form.