

LEAVE REQUEST FORM – UNION

| EMPLOYEE INFORMATION | |
|--|--|
| Employee Name: | Employee Location: |
| REASON FOR LEAVE OF ABSENCE (check all that apply) | |
| <p>More than one type of leave may apply, and some leaves run concurrently.</p> | |
| Medical Leave | Paid Family Leave |
| <input type="checkbox"/> Employee Medical Leave <input type="checkbox"/> Care for Family Member (FMLA) <input type="checkbox"/> Military Leave | <input type="checkbox"/> Baby Bonding <input type="checkbox"/> Care for Family Member (PFL) <input type="checkbox"/> Service Member Care/ Exigency Leave |
| <input type="checkbox"/> Personal Leave not covered by any other options <input type="checkbox"/> Employee Medical Leave(non-FMLA) | |
| LEAVE TIMEFRAME | |
| <p>1. <input type="checkbox"/> I am requesting consecutive leave (2 weeks or longer) for the following dates:</p> <p>Beginning on (date): _____ Ending on (date): _____</p> | |
| <p>2. <input type="checkbox"/> I am requesting intermittent leave per the following schedule: (Intermittent leaves should have a set schedule and duration. Ex: Work 3 days, M-W-F for 1 month, starting ___ date.)</p> | |

PAY WHILE ON LEAVE (check all that apply)

To be sure you can plan appropriately, you must specify what type of pay you wish to receive, based on the type of leave and your eligibility. Please select from the following option(s):

1. Employee Medical Leave
 - a. Required – Use Sick Accruals until depleted then,
 - b. STD Salary Continuation @ 50% -- Maximum \$750/week
 - **Required** – You must apply for STD benefits through the Hartford.
2. Paid Family Leave to care for a family member with a serious health or condition (or other applicable):

- **Required** – You must also apply for NY PFL through the Hartford.

Pay options:

- Receive Paid Family Leave (PFL) benefit only (administered by The Hartford)

OR

- Receive PFL and Subsidize with Sick Vacation Floating Holiday

3. Family Leave -- Accruals Only

Check all that apply: Sick Vacation Floating Holiday

4. Unpaid Leave – not covered by any policy and no accrued time available

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 and preferred phone # where we can reach you while on leave.

Email: _____ Phone # _____

MANAGER ACKNOWLEDGEMENT

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