Yeshiva University

YESHIVA UNIVERSITY
FMLA LEAVE REQUEST FORM

An employee must submit an application to the University Benefits Office for FMLA leave, with medical certification, at least 30 days in advance when the need for leave is either foreseeable or non-emergency in nature.

Employees who have accrued paid leave may be allowed or required to substitute the same for any part of the leave provided for under FMLA.

If an ***FMLA leave is approved*** by the University Benefits Office, health insurance coverage will be continued by the employer for the period of approved leave under the same terms and conditions applicable to employees actively at work. ***If the request for unpaid leave is not approved as FMLA leave,*** health insurance and other benefit coverage ***may*** be discontinued when the leave begins, unless the employee and the employer make arrangements to continue coverage.

Employees represented by 1199 and the State Nurses Association will continue for the term of the FMLA leave to receive health benefits at the same level and upon the same contractual conditions ***if they qualify for an FMLA leave.***

Staff covered under the University's benefit programs should request FMLA continuation of benefits information from the University Benefits Office. The University Benefits Office will provide detailed information regarding the benefit continuation options and the contribution requirements. Staff is required to contribute toward the premium cost of their health insurance (and other benefits), if they wish to continue such coverage while on FMLA leave. ***The University has the right, (with certain employees) to recover the health care premiums it paid during an approved FMLA leave period, if the employee fails to return from the leave.***

To be completed by Employee:

Last Name _____ First Name _____ MI ____

SS#_____ Dept. _____ Tel#. _____ Hrs worked/week _____

1) **Reason for Leave** *(please check one box)*

- ☐ Birth of a child or placement of a child for foster care or adoption
- ☐ Employee's own serious health condition
- ☐ To care for a child, spouse or parent who has a serious health condition
- ☐ A qualifying exigency that occurs because the employee's spouse, parent, son or daughter or parent who is serving in the National Guard or Reserves is serving on or has been called to active duty in the U.S. Armed Forces.
- ☐ To care for a qualifying family member who incurred a serious injury or illness in the line of duty while on active duty in the Armed Forces.

2) Type of Leave *(please check one box)*

☐ **Continuous** FMLA Leave

Start date _____ End Date _____ Total #hours requested _____

☐ **Intermittent** FMLA Leave

Starting (date)_____ my anticipated schedule of absences is as follows (attach an additional sheet if needed) _____.

☐ **Reduced work schedule** FMLA Leave from _____ hours/week to _____ hours/week starting (date) _____ to _____ hours/week ending (date) _____.

Intermittent or reduced work schedule leave is medically necessary because (attach an additional sheet if needed).

_____

_____.

If your FMLA leave is approved, do you wish to use available vacation time while on FMLA leave?

☐ Yes
☐ No

Employee Statement of Understanding

I am aware of and understand the following:

- I must return all necessary documentation including certifications and/or forms to the Benefits Office as requested once I receive a Notice of Eligibility and Rights & Responsibilities informing me whether or not I am eligible to take the FMLA leave. Failure to do so may result in my leave being delayed until I provide this documentation.
- Before I return to work following a leave for my own serious health condition, I will be required to provide certification from a health care provider that I am medically able to resume work.
- My health benefits will continue during my leave and I am expected to continue to pay my share of health insurance premiums, if any;
- If I fail to return to work upon the conclusion of this leave, I may be subject to disciplinary proceeding or other action in accordance to University policies, rules and regulations, and applicable collective bargaining agreements.

_____ _____

Employee Signature *Name of Supervisor/Administrator*

Please return this form to the University Benefits Office, Room 1203, Belfer Building, Bronx NY