NEW YORK CITY
HOUSING
AUTHORITY

FAMILY MEDICAL LEAVE MEDICAL (FMLA)
PROVIDER CERTIFICATION (3/31/15)

TO BE COMPLETED BY EMPLOYEE

Please complete this section before providing this form to the medical provider. Failure to provide complete and sufficient medical certification may result in denial of your FMLA request.

Employee's Name	ID#	Title	Regular Work Schedule

Home Address	City	State/Zip	Telephone#

Department/Division	Supervisor's Name

Type of Leave: ☐ **Continuous** ☐ **Intermittent**

Leave Reason: *(Select one)*

- ☐ Birth of a child and to care for the newborn child
- ☐ Placement of a child for adoption or foster care
- ☐ Care of my own serious health condition
- ☐ Care of child with serious health condition
- ☐ Care of a parent with a serious health condition
- ☐ Care of a spouse with a serious health condition

TO BE COMPLETED BY HEALTH CARE PROVIDER

The employee noted above has requested leave under FMLA. Please fully answer all questions below. Answers should be your best estimate based upon medical knowledge, experience and examination of the patient. Be specific, terms such as lifetime, unknown and undetermined may not be sufficient to determine FMLA coverage. For your convenience, attached is the employee's job description which details his/her essential job functions.

MEDICAL FACTS

Patient Name		
Relationship to Employee *(Circle one)* Self Child Spouse Parent	**Approximate Date Condition Commenced**	**Probable Duration of Condition**

1. Was the patient admitted for an overnight stay in hospital, hospice or residential medical care facility?
   ☐ No ☐ Yes If yes, date(s) of admission _____
2. Date(s) you treated the patient for condition: _____
3. Is the medical condition pregnancy? ☐ No ☐ Yes If yes, expected delivery date _____

CONTINUOUS ABSENCE-*Complete Section if Unable to Work Continuously or if Care for a Family Member is Required Constantly*

4. Will the patient be incapacitated for a single continuous period of time, including any time for treatment and recovery?
   ☐ No ☐ Yes If yes, estimate the beginning and ending dates for the period of incapacity _____
   _____
5. During this time, will the patient need care by a family member? ☐ No ☐ Yes If Yes, if *yes*, how long will the employee's presence be necessary to assist the family member? _____

   Describe care the family member will be required to provide. _____
   _____
   _____

FAMILY MEDICAL LEAVE
HEALTH CARE PROVIDER CERTIFICATION *(Page 2)*

Employee's Name	ID#

INTERMITTENT ABSENCE-*Complete Section if Unable to Work Intermittently or Care for a Family Member is Required Periodically*

6. Will the patient require <u>follow-up treatments</u>, including time for recovery? ☐ No ☐ Yes If yes, estimate the treatment schedule, including the dates of any scheduled appointments and the time required for each appointment including any recovery period. _____

_____

_____

7. Will the patient require <u>care on an intermittent or reduced schedule basis</u>? ☐ No ☐ Yes If Yes, estimate the number of hours _____ per ☐ day ☐ per week the patient needs care on an intermittent basis.

- -

Explain the care needed for the patient and why such care is medically necessary: _____

_____

_____

8. During this time, will the patient need care by a family member? ☐ No ☐ Yes If Yes, If *yes*, how long will the employee's presence be necessary to assist the family member? _____

Describe the care the family member will be required to provide. _____

_____

_____

9. Will the condition cause episodic flare-ups periodically preventing the patient from participating in work activities? ☐ No ☐Yes If *Yes*, estimate the frequency of flare-ups and the duration of related incapacity that the patient may have over the next 6 months. _____

_____

_____

10. Does the patient need care during these flare-ups? ☐ No ☐Yes If *Yes*, explain the care needed by the patient and why such care is medically necessary: _____

_____

_____

ADDITIONAL INFORMATION- Describe other medical facts, if any, related to the condition for which the patient needs care:

_____

_____

_____

Health Care Provider's Name	Health Care Provider's Business Address
Type of Practice	**Health Care Provider's Telephone#**

_____ _____

Signature of Health Care Provider Date

New York City Housing Authority
Human Resources Department – Records Control Division

YOUR RIGHTS UNDER FAMILY AND MEDICAL LEAVE ACT (FMLA)

The Family and Medical Leave Act (FMLA) is a Federal law which entitles eligible Authority employees to a leave of absence for the birth of a child or for the serious illness of the employee or covered family members.

A Serious Health Conditions means an illness, injury, impairment or physical or mental condition that involves one of the following:

1. ***Hospital Care – Inpatient Care*** (i.e. overnight stay) in a hospital, hospice or residential medical care facility.

2. ***Absence Plus Treatment***
    a. A period of incapacity of more than three consecutive calendar days plus treatment of more than three consecutive calendar days.
    b. Treatment by a health care provider on at least one occasion which results in a regimen of continuing treatment under the supervision of a health care provider.

3. ***Pregnancy*** – Any period of incapacity due to pregnancy or prenatal care.

4. ***Chronic Condition Requiring Treatments*** – A chronic condition which
    a. Requires periodic visits for treatment by a health care provider nurse or physician's assistant under direct supervision of a health care provider.
    b. Continues over extended period of time
    c. may cause episodic rather than a continuing period of incapacity such as asthma, diabetes, epilepsy

5. ***Permanent/Long-term Condition Requiring Supervision*** - A period of incapacity which is permanent or long term due to a condition for which treatment may not be effective. The employee or family member must be under the continuing supervision of but need not be receiving active treatment by a health care provider. Examples include Alzheimer's, a severe stroke or the terminal stages of a disease.

6. ***Multiple Treatment (Non-Chronic Conditions)*** - Any period of absence to receive multiple treatments by a health care provider that would result in a period of incapacity of more than 3 consecutive days in the absence of medical intervention or treatment example chemotherapy, radiation, physical therapy and dialysis.

New York City Housing Authority
Human Resources Department – Records Control Division

YOUR RIGHTS UNDER FAMILY AND MEDICAL LEAVE ACT (FMLA) – *Page 2*

To qualify for FMLA the employee must have worked for the Authority for at least 12 months and have worked at least 1250 hours during the 12 month period preceding the leave.

- Eligible employees are entitled to 12 weeks of leave in a 12 month period.
- Each time an employee take a leave under FMLA, (s)he is entitled to a maximum of 12 weeks minus any amount of FMLA leave that the employee may have taken during the preceding 12 months.
- A total of 26 weeks of leave in a single 12-month period to care for a spouse, son, daughter, parent or next of kin who is a member of the Armed Forces, including a member of the National Guard or Reserves undergoing medical treatment, recuperation or therapy, is otherwise in outpatient status, or is otherwise on the temporary disability retired list, for a serious injury or illness.
- If the leave is to care for a family member, along with medical documentation, you must provide proof of relationship. This includes birth certificate, court documents, foster care certification, etc.
- Annual leave and compensatory time balances must be used concurrently with the FMLA leave. Upon exhaustion of all leave balances, the remainder of the FMLA leave entitlement period will be unpaid.
- Any time spent on unpaid leave is not counted as service for accrual purposes or in pension and retirement bonus calculations.
- Group health insurance is maintained for an employee on a FMLA leave. However, the Authority may recover its share of health insurance premiums for the period of time the employee was on unpaid leave if the employee does not return to work after the FMLA leave has expired.
- Employees on FMLA leave for his/her own serious health conditions are required to provide medical documentation *(dated within 5 days prior to your return date)* certifying fitness to return to work before reassignment.
- Employees returning to work from a FMLA leave must be restored to his/her previous position or to an equivalent position. An equivalent position is one that offers the same civil service title, pay, benefits and working conditions. However, if the employee does not return following the expiration of the FMLA leave (s)he may not be restored to the same or equivalent position held prior to the commencement of such leave.

HOW YOUR LEAVE OF ABSENCE MAY AFFECT YOUR HEALTH INSURANCE

- During your leave with pay, your health insurance coverage will continue.
- During your leave without pay, for illness leave, workers' compensation, Family Medical Leave or military leave, you may be eligible for continuation of your health insurance coverage.

If you are on leave without pay, you will receive a separate letter regarding your eligibility to receive continued health coverage.

For further information outlining your rights and obligations under the Family Medical Leave Act, or if you have questions regarding your health insurance coverage, contact HR's Customer Service Unit, ASK HR at (212) 306-8000.

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