Montefiore HR CENTRAL LEAVE ADMINISTRATION OFFICE

ASSOCIATE LEAVE REQUEST FORM

NON DISABILITY RELATED LEAVES

ALL FIELDS MUST BE COMPLETED FOR REQUEST TO BE PROCESSED ON A TIMELY BASIS.

FOR OFFICE USE ONLY
(Attach Barcode Label)

PART ONE: COMPLETED BY ASSOCIATE

IN EMERGENT SITUATIONS, WHEN ASSOCIATE IS UNABLE TO COMPLETE THE FORM, MANAGERS/NURSING ADMIN. OFFICE SHOULD INITIATE THIS REQUEST.

CHECK HERE IF THIS SECTION WAS COMPLETED BY MANAGER ☐

ASSOCIATE - YOU WILL BE NOTIFIED OF THE STATUS OF YOUR LEAVE REQUEST, BY THE HR CENTRAL LEAVE ADMINISTRATION OFFICE WITHIN 5 BUSINESS DAYS FROM THE RECEIPT OF THIS FORM. FOR ANY ADDITIONAL QUESTIONS CONTACT THE HR CENTRAL LEAVE ADMINISTRATION OFFICE AT CONTACT INFORMATION LISTED BELOW.

Associate Name:		Department:
Associate Job Title:	Associate EZ ID #:	Division:

Type of Leave: *(Select as appropriate)*

☐ Family and Medical Leave – **Non Disability Related**
☐ Intermittent or ☐ Continuous

- ☐ My Own Serious Health Condition
  (when available any accrued unused sick time will automatically be deducted)
- ☐ Birth of my child/ Care of my newborn *(Other than pregnancy maternity leave)*
- ☐ Placement of child/adoption or foster care
- ☐ Care for family member serious health condition
  ☐Spouse ☐Child ☐Parent ☐Same sex domestic partner
  and /or in accordance with my collective bargaining agreement -
  Provide relationship of family member: _____
- ☐ Qualifying emergency (exigency) arising out of
  ☐Spouse ☐Son/Daughter ☐Parent, being on active duty or called to active duty status in support of a contingency operation as a member of the National Guard or Reserves
- ☐ Covered Service Member with a serious injury/illness
  ☐Spouse ☐Child ☐Parent ☐Next of Kin ☐Same sex domestic partner

☐ Education
☐ Military
☐ Reserve Duty
☐ Personal
☐ Union Business

Requested Leave Start Date :	Expected Date of Return :
Associate Signature:	Date Form Submitted:

Associate Best Contact Information:

Street Address: Apt/Unit: City: State: Zip Code:

Home Tel#: Cell Tel#: Personal Email:

ASSOCIATES ARE REQUIRED TO MAINTAIN COMMUNICATION WITH THEIR MANAGER ABOUT THE STATUS OF THEIR EXPECTED DATE OF RETURN

PART TWO: COMPLETED BY ASSOCIATE'S MANAGER/NURSING ADMIN. OFFICE

MANAGER/NURSING ADMIN. OFFICE – FORWARD COMPLETED FORM TO HR CENTRAL LEAVE ADMINISTRATION OFFICE FOR PROCESSING. MAINTAIN A COPY FOR YOUR RECORDS AND USE THE COPY TO RE-SUBMIT TO PROCESS SECTION 2B AN EXTENSION OF THE CURRENT LEAVE AND/OR SECTION 2C THE ASSOCIATE'S RETURN TO WORK (PAGE 2).

FOR ANY ADDITIONAL QUESTIONS CONTACT THE HR CENTRAL LEAVE OFFICE AT THE CONTACT INFORMATION LISTED BELOW

SECTION 2A – LEAVE REVIEW AND APPROVAL PROCESS

Check as applicable:
☐ NYSNA ☐ Local 1199 ☐ Local 1 ☐ APTA ☐Local 30 ☐ Management/Non Union ☐ Physician/Scientist

Requested Accrued Time to be taken: (*Other than for Associates' Own Serious Health Condition)*

Vacation Time:	Choice Time:	Hospital/Personal Holiday Time:
Last Day Worked:	Any Leave taken in the last 12 months including Intermittent Leave? ☐ Yes ☐No	

NOTE: *FMLA Eligibility Criteria:*
*Associate must be employed for at least 12 months **and** must have worked at least 1,250 hours excluding paid vacation, hospital and personal holidays and sick leave hours in the preceding 12 month period.*

DIRECTOR/MANAGER'S RECOMMENDATION: (*Where applicable – for Education, Personal or Union Business Leaves **ONLY***)

☐ To approve Leave ☐ To deny Leave *(Requires comment below)*

Comments:

Print Name of Manager: Manager Tel.#:

Manager Signature: Date Form Completed:

ASSOCIATE LEAVE REQUEST FORM

PART TWO CONT'D: COMPLETED BY ASSOCIATE'S MANAGER/NURSING ADMIN. OFFICE

SECTION 2B – LEAVE EXTENSION AND APPROVAL PROCESS

Date of Associate Leave Extension Request:	Amended Expected Date of Return:

DIRECTOR/ MANAGER'S RECOMMENDATION - LEAVE EXTENSION: (*Where applicable – for Education, Personal or Union Business Leaves **ONLY***)

☐ To approve Leave Extension ☐ To deny Leave Extension*(Requires comment below)*

Comments:

Print Name of Manager: Manager Tel.#:

Manager Signature: Date Form Completed:

SECTION 2C – RETURN FROM LEAVE PROCESS

Date Associate Returned to Work:	Associate Cleared by OHS ☐ Yes ☐ No ☐N/A *If Cleared by OHS,* Date of Clearance:

Print Name of Manager: Manager Tel.#:

Manager Signature: Date Form Completed:

PART THREE: COMPLETED BY HR CENTRAL LEAVE ADMINISTRATION OFFICE

SECTION 3A – LEAVE REVIEW AND APPROVAL PROCESS

Labor Relations contacted? ☐ Yes ☐Not Applicable

If Yes, Name Labor Relations Office Case Reviewer: Date Contacted:

FINAL LEAVE DECISION: ☐ Leave Approved ☐ Leave Denied Date of Decision:

Contacted Associate: By Email ☐ Phone Call ☐ Date Contacted:	Updated Genesys: Date:

Contacted Manager to Update Associate Schedule: Manager Name: Date Contacted:

HR Central Leave Administration Office Case Reviewer:

Name: Signature: Date:

SECTION 3B – LEAVE EXTENSION REVIEW PROCESS

Labor Relations contacted? ☐ Yes ☐Not Applicable

If Yes, Name Labor Relations Office Case Reviewer: Date Contacted:

FINAL LEAVE EXTENSION DECISION: ☐ Leave Extension Approved ☐ Leave Extension Denied Date of Decision:

Contacted Associate: By ☐ Email ☐Phone Call Date Contacted:	Updated Genesys: Date:

Contacted Manager to Update Associate Schedule: Manager Name: Date Contacted:

HR Central Leave Administration Office Case Reviewer:

Name: Signature: Date:

SECTION 3C – RETURN FROM LEAVE PROCESS

Date form Received:	Date Associate Returned to Work:

Labor Relations contacted? ☐ Yes ☐Not Applicable

If Yes, Name Labor Relations Office Case Reviewer: Date Contacted:

HR Central Leave Administration Office Case Reviewer:

Name: Signature: Date:

Date form given to HRIC:

PART FOUR: COMPLETED BY HRIC

Date form Received:

Adjustments made to Associate profile:

MMC Current Experience Date	M	M	D	D	Y	Y	
MMC Deferred Experience Date	M	M	D	D	Y	Y	

Comments:

HRIC Case Reviewer:

Name: Signature: Date: