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.

Associate Name:	**Associate EZ ID #:**

Requested Leave Start Date :	**Expected Date of Return** :	**Department:**

Type of Leave: ***Please select***

☐ **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

Associate Signature: Date Form Submitted:

Associate Best Contact Information:

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

Home Tel#: Cell Tel#: Personal Email:

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

MANAGER/NURSING ADMIN. OFFICE – FORWARD COMPLETED FORM TO HR CLAO FOR PROCESSING.

SECTION 2A – LEAVE REVIEW FOR FMLA: *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.*

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

SECTION 2B- EDUCATION, PERSONAL, OR UNION BUSINESS LEAVES ONLY

DIRECTOR/MANAGER'S RECOMMENDATION:

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

Manager Name: Manager Signature:	Date Form Completed:

ASSOCIATE LEAVE REQUEST FORM

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

SECTION 2C – LEAVE EXTENSION AND APPROVAL PROCESS

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

DIRECTOR/ MANAGER'S RECOMMENDATION - LEAVE EXTENSION: ***Education, Personal or Union Business Leaves ONLY***

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

Manager Signature: Date Form Completed:

SECTION 2D – 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 3 – 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: