

TOWN OF NISKAYUNA FMLA POLICY

The Family and Medical Leave Act (FMLA) is a federal law which permits eligible employees to take up to 12 weeks leave without pay due to parenthood or a serious health problem of an employee or a family member. To be eligible, an employee must have been employed by the Town for at least 12 months and have worked at least 1,250 hours in the 12 months preceding the commencement of the leave.

Reasons for FMLA leave

If eligible, you are entitled to up to 12 weeks of leave in a 12 month period. A “12-Month Period” means a rolling 12-month period measured backward from the date leave is taken and continuous with each additional leave day taken. FMLA leave is available for these reasons:

1) the birth of a son or daughter or placement of a son or daughter with an employee for adoption or foster care. The entitlement in this case expires 12 months after the birth or placement. There is no maximum age limit for adoption or foster care placement.

2) to care for a spouse, child, or parent who has a serious health condition. Caring for someone includes psychological as well as physical care. It also includes acquiring care and sharing care duties. A “spouse” means a husband or wife as recognized by State law. The term does not include unmarried domestic partners. If both spouses work for the Town, their total leave in any 12-month period will be limited to an aggregate of 12 weeks if the leave is taken for either the birth or placement for adoption or foster care of a child or to care for a sick parent. A “child” is defined as a person under 18 years of age (or a person incapable of self-care because of a physical or mental disability) who is a biological, adopted, foster, or step child, your ward, or a person with whom you are charged with a parent’s rights, duties and responsibilities. An eligible “parent” includes a biological parent or a person who was charged with a parent’s rights, duties, and responsibilities over you when you were under legal age, but doesn’t include your in-laws, if any.

3) because of a serious health condition making you unable to perform the essential functions of your position. A serious health condition is defined in federal law and regulations, but generally includes an incapacity requiring absence from work of more than three (3) days that also involves continuing treatment by a health care provider. This also includes prenatal care.

Notice requirement

Thirty days written notice is required if the leave is foreseeable. If 30 days notice is not possible, as much notice as practical must be given. Planned medical treatment should be scheduled so that it will not unduly disrupt Town operations. The Town Board shall review reasons given for a requested FMLA leave and shall determine whether such leave shall be granted.

Effect on health insurance

Health insurance coverage will be maintained at the same level and under the same terms as if you continued to work. Contact the Town Comptroller to arrange for payment of your portion of premiums.

Incumbents of FMLA leave

Family and medical leave may be taken in increments up to the full 12 weeks and, depending on the circumstances, as small as the minimum amount of time allowed under the Town's Employee Handbook or your negotiated labor agreement, as the case may be.

Use of accrued sick leave, compensatory time, and vacation during FMLA leave

Time spent on unpaid FMLA leave will not count toward seniority. Any employment benefit that you have accrued prior to use of FMLA leave is protected and will be maintained. The employee may choose to exhaust paid leave benefits before beginning an unpaid FMLA leave, or may choose to keep them intact pending return to work.

Medical and fitness for duty certifications

Certification by your physician will be required for FMLA leave due to your own serious health condition or that of a child, parent or spouse. Additional opinions may be requested by the Town. If such is requested, the Town will pay for the cost of any additional opinion and will select a health care provider for that purpose.

Recertification may be required if you request an extension of the original length approved by the Town or if your circumstances change. Recertification may also be required if there is a question as to the validity of the certification or if you are unable to return to work due to a serious health condition. The Town may require a medical certificate attesting to your fitness for duty prior to return to work. A fitness for duty report must be based on the particular health condition(s) for which FMLA leave was approved and must address whether you can perform the essential functions of your job. A Town representative may consult with a physician or other expert to determine reasonable accommodations for any employee who is disabled and protected under ADA (Americans with Disabilities Act). If a fitness for duty certification is required, the Town will deny reinstatement until it is provided.

Records retention

Records on FMLA leave will be kept along with normal payroll records except that, in accordance with FMLA, any medical record will be maintained separately as a confidential medical record.

Training

If you miss training sessions while on FMLA leave, you will be given a reasonable opportunity to make up the training.

Return from FMLA leave

Upon return from FMLA leave, you have a right to return to your same position, or, if the former position no longer exists, an equivalent position. Your health insurance coverage will continue at the same level and under the same conditions without requiring a physical exam, qualifying period, or exclusion of pre-existing conditions.

Further information

A copy of the federal law and regulations and any forms required by the Town for completion by you or a health care provider may be obtained from the Town Comptroller.

TOWN OF NISKAYUNA
REQUEST FOR FAMILY AND MEDICAL LEAVE (FMLA)

Employee Name:

Department:

Title:

I request a FMLA leave for the following reason (check one):

- A. The birth of a child and in order to care for such child or the placement of a child for adoption or foster care.
- B. To care for (Circle one: CHILD – SPOUSE – PARENT) if such family member has a serious health condition. You must submit “Physician or Practitioner Certification” within 15 days.
- C. My own serious health condition makes me unable to perform my job functions.
You must submit “Physician or Practitioner Certification” within 15 days.

TYPE OF LEAVE REQUESTED

- A. Continuous Leave
- B. Intermittent or Reduced Work Schedule Leave (Specify):

Date leave is to begin:

Expected duration of leave:

If the duration of my FMLA leave (total of paid and unpaid time) does not exceed 12 weeks, I will be returned to my same or equivalent position. I understand that if my FMLA leave should exceed 12 weeks, I will be returned to my same or similar position, only if available, in accordance with applicable laws. If my same or similar position is not available, I understand that I may be terminated.

The Town retains the legal right to recover from me the cost of all group health insurance premiums paid by it during any unpaid FMLA leave should I fail to return to work at the end of the leave, unless my failure to return is protected under FMLA or is due to circumstances beyond my control. If my failure to return is not protected or excusable for the reason cited above, I agree to coordinate with the Town Comptroller a schedule to promptly repay the Town for premium it paid to maintain my coverage for health insurance while on unpaid leave.

I certify by my signature that I have read this document and agree to its terms.

Employee Signature

Date submitted to
Department Head: _____

CERTIFICATION OF PHYSICIAN OR PRACTITIONER
(Family and Medical Leave Act of 1993)

1. Employee's Name: _____

2. Patient's Name (If other than employee): _____

3. Diagnosis:

4. Date condition commenced: _____ 5. Probable duration of condition: _____

6. Regimen of treatment to be prescribed: (indicate number of visits, general nature and duration of treatment, including referral to other provider of health services. Include schedule of visits, or treatment, if it is medically necessary for the employee to be off work on an intermittent basis, or to work less than the employee's normal schedule of hours per day, or days per week).

a. By Physician or Practitioner:

b. By another provider of health services, if referred by Physician or Practitioner:

IF THIS CERTIFICATION RELATES TO CARE FOR THE EMPLOYEE'S SERIOUSLY-ILL FAMILY MEMBER, SKIP ITEMS 7, 8 AND 9 AND PROCEED TO ITEMS 10 THROUGH 14. OTHERWISE, CONTINUE BELOW.

Check **Yes** or **No** in the boxes below, as appropriate.

- | | Yes | No | |
|----|--------------------------|--------------------------|---|
| 7. | <input type="checkbox"/> | <input type="checkbox"/> | Is inpatient hospitalization of the employee required? |
| 8. | <input type="checkbox"/> | <input type="checkbox"/> | Is employee able to perform work of any kind? (If " No ", skip Item 9.) |
| 9. | <input type="checkbox"/> | <input type="checkbox"/> | Is employee able to perform functions of employee's position? (Answer after reviewing statement from employer of essential functions of employee's position, or, if none provided, after discussing with employee.) |

FOR CERTIFICATION RELATING TO CARE FOR THE EMPLOYEE'S SERIOUSLY-ILL FAMILY MEMBER, COMPLETE ITEMS 10 THROUGH 14

BELOW AS THEY APPLY TO THE FAMILY MEMBER, AND PROCEED TO ITEMS 15-17.

- | | Yes | No | |
|-----|--------------------------|--------------------------|---|
| 10. | <input type="checkbox"/> | <input type="checkbox"/> | Is inpatient hospitalization of the family member (patient) required? |
| 11. | <input type="checkbox"/> | <input type="checkbox"/> | Does (or will) the patient require assistance for basic medical, hygiene, nutritional needs, safety, or transportation? |
| 12. | <input type="checkbox"/> | <input type="checkbox"/> | After review of the employee's signed statement (See Item 14 below), is the employee's presence necessary, or would it be beneficial for the care of the patient? (This may include psychological comfort.) |
| 13. | | | Estimate the period of time that care is needed, or the employee's presence would be beneficial: _____ |

ITEM 14 IS TO BE COMPLETED BY THE EMPLOYEE NEEDING FAMILY LEAVE.

14. When Family Leave is needed to care for a seriously-ill family member, the employee shall state the care he or she will provide, and an estimate of the time period during which this care will be provided, including a schedule if leave is to be taken intermittently, or on a reduced leave schedule:

Employee signature: _____

Date: _____

15. Signature of Physician or Practitioner: _____

16. Date: _____

17. Type of Practice (Field of Specialization, if any):