CITY OF NEW HAVEN
APPLICATION for LEAVE OF ABSENCE
& FAMILY AND MEDICAL LEAVE

I. TO BE COMPLETED BY EMPLOYEE:

Employee Information

Name ____ Employee # ________________

Address ____

City ____ State _______ Zip _________________________

Primary Phone # __________________________ Secondary Phone # _________________________

Primary E-mail Address ____

Department Employed __________________________ Union Affiliation __________________________

Job Title ____

Type of Leave Request

I am requesting the following type of Leave Of Absence:

☐ FMLA (non-intermittent) ☐ Medical ☐ Personal

Start Date of Anticipated Leave ________________________ Expected Date of Return ___________________

☐ I elect to use any outstanding vacation, personal, and sick hours during my leave

☐ I do not elect to use any outstanding vacation, personal, and sick hours during my leave (unless otherwise required by the employees collective bargaining agreement)

Reason for Leave (Explain) ____

Please read and initial next to each statement below:

_______I understand that the City of New Haven will pay its portion of the cost of the employee's health, dental, life and disability insurance benefits, as applicable, while an employee is on LOA (excluding Civil Service Leaves). The employee must continue to pay their portion of the benefits, either by payroll deductions (if on paid leave), or by check (if on unpaid leave) which must be submitted to the Human Resource Department each pay period, unless other arrangements have been agreed upon by the employee and the Human Resources Department. The employee's coverage under the group health plan shall be under the same conditions as would have been provided if the employee had been continuously employed during the entire approved LOA period.

_______I understand that if I fail to pay my portion of the benefits for more than 30 days, the my benefits will be terminated and I will be offered Consolidated Omnibus Budget Reconciliation Act (COBRA) coverage to continue health and dental benefits.

_______I understand that every attempt will be made to restore me to my original position upon return from leave. If my original position is unavailable, I will be placed in an equivalent position with equivalent pay and benefits (unless otherwise required by my collective bargaining agreement).

_______I understand that a failure to return to work at the end of my leave period may be treated as a resignation.

For FMLA and Medical Requests:

_______I understand that as a condition of restoration from a FMLA or medical leave that I must provide my employer a written certification from my health care provider stating that I am able to resume working.

Return to Human Resources
hr@newhavenct.gov or via fax 203-946-7166

_______I understand that a FMLA or Medical leave request based on an employee's serious health condition, or the serious health condition of an employee's spouse, child or parent must be accompanied by a verifying medical certification from a physician.

_______I understand that:

- A certification is considered “incomplete” if one or more of the applicable entries on the form have not been completed.
- A certification is considered “insufficient” if the information provided is vague, unclear, or non-responsive.

_______I understand that my employer may request medical recertification during the same leave year, no more often than every 30 days for a short-term condition or after six months for a longer-term condition, or sooner if, for example, the medical circumstances have changed significantly.

_______I hereby authorize the City of New Haven, its employees and agents to contact my physician to verify the reason for my requested leave or for any other information concerning my requested family and medical leave.

_______I understand that in the event that I fail to return from leave after the expiration of the FMLA or Medical leave period, that I will be liable for both mine and the City’s share of the insurance premiums incurred during the leave, unless the reason that I don’t return is due to the continuation of a serious health condition or of my family member or other circumstances beyond my control as set forth in 29 CFR 825.213. In such instances, medical certification may be required. The cost of the certification shall be my responsibility and I am not entitled to be paid for the time or travel costs spent in acquiring the certification. If my employer requests medical certification and I do not provide such certification in a timely manner (not to exceed 30 days absent exigent circumstances), or the reason for not returning to work does not meet the test of other circumstances beyond my control, the employer may recover 100% of the health benefit premiums it paid during the period of unpaid FMLA or Medical leave.

_______I understand that I may choose not to retain group health plan coverage during FMLA or Medical leave. However, when I return from leave, I am entitled to be reinstated on the same terms as prior to taking the leave, including family or dependent coverage, without any qualifying period, physical examination, exclusion of pre-existing conditions, etc.

Employee’s Signature ____**Date** _________________________

II. TO BE COMPLETED BY DEPARTMENT HEAD OR COORDINATOR:

Department Head/Coordinator's Signature____________________________ Date________________

For Personal Leave Only (not FMLA/Medical Leave)

Approval of this leave will cause significant operational issues. Yes ☐ No ☐

III. TO BE COMPLETED BY DIRECTOR OF HUMAN RESOURCES:

Check one: ☐ Leave Approved for: ___________ Days/Weeks

☐ Leave Denied (explain): ____

Director's Signature ____ Date _______________

IV. TO BE COMPLETED BY FMLA COMMITTEE IN CASE OF APPEAL:

Check one: ☐ Leave Approved for: ___________ Days/Weeks

☐ Leave Denied (explain): ____

Committee's Signature ____ Date ________________