Niagara Falls City School District Office of Human Resources
630-66th Street, Niagara Falls, NY 14304
(716) 286-4225 (Phone) (716) 286-4224 (Fax)

Staff Leave/Medical Request

Employee: _____ Phone: _____

Home Address: _____

Position: _____ Location: _____

Please check reason for Leave

	Type of Leave (Select one:)		From		Through
	Medical (Must provide medical certification) 1. Own serious health condition (not work related) 2. Maternity: Care for newborn/placed child **Benefits continue while using sick days/sick bank**				
	FMLA (Unpaid Leave). Must provide medical certification: 1. Own serious health condition (not work related) 2. Maternity: Care for newborn/placed child 3. Care for parent/spouse/child w/serious health condition **Benefits continue only for 12 weeks of approved FMLA (60 days)**				
☐	**Personal (Unpaid Leave).** Must provide letter giving brief description of reason for leave. **Not entitled to Benefits**				
☐	**Educational (Unpaid Leave).** Must provide brief description of need for leave and documentation to support enrollment in a college program. **Not entitled to Benefits**				
☐	**Military leave (Unpaid Leave) Must attach orders.** **Benefits continue only for 12 weeks of approved FMLA (60 days)**				
☐	**Other: Leave to take other position in District**				

A leave of absence may consist of leave without pay and/or paid leave (i.e. vacation, personal illness, etc.) Paid leave may be used in accordance with applicable policy/contracts.

Anticipated Date for Maternity Leave _____

Pregnancy Leave _____ 6 Weeks OR _____ 8 Weeks

Child Rearing (FMLA, Unpaid Leave)_____12 Weeks OR _____ One (1) Semester

Employee Signature:_____

Date_____

Designation of Leave

To be completed by HRO Department:

_____ Your leave is denied for the following reason(s)_____

_____ Your leave has been approved

Date Employee Notice of Approval Sent _____

Date FMLA Notice sent out:_____

Signature:_____ Date:_____

Administrator for Human Resources

Niagara Falls City School District
Office of Human Resources
630-66th Street Niagara Falls, NY 14304
716-286-4225

Certification Health Care Provider Form
(Non FMLA Leave)

Instructions

This form is intended for use to substantiate the need for use of personal or medical leave due to medical conditions. Do not use this form if requesting leave under FMLA.

If you are (1) applying for a leave of absence that involves your own medical condition, or (2) have been asked to provide information to the district to substantiate a personal or medical leave, please follow these steps:

1. Take this form to the health care provider who is treating you.
2. Ask the health care provider to complete this form and return it to you as soon as possible. (In emergency situations, the health care provider may fax it to (716) 286-4224.

The Genetic Information Nondiscrimination Act of 2008 (GINA) prohibits employers and other entities covered by GINA Title II from requesting or requiring genetic information of employees or their family members. In order to comply with this law, we are asking that you not provide any genetic information when responding to this request for medical information. “Genetic information,” as defined by GINA, includes an individual's family medical history, the results of an individual's or family member's genetic tests, the fact that an individual or an individual's family member sought or received genetic services, and genetic information of a fetus carried by an individual or an individual's family member or an embryo lawfully held by an individual or family member receiving assistive reproductive services.

3. The employee should return this form (completed) to:

Human Resources
Attn: Ms. Maria Massaro
630-66th Street
Niagara Falls, NY 14304
Fax: 716-286-4224

Approval of your leave of absence or use of sick leave may be delayed or denied if this form is not completed and/or submitted timely with your Leave Request Form.

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716-286-4225

Certification of Health Care Provider

Health Care Provider: When completed, this form goes to the employee or may be faxed to: Human Resources (716) 286-4224.

Patient's Name: _____

1. Describe the medical facts which support your certification.

2. State the approximate date the condition commenced, and the probable duration of the condition (and also the probable duration of the patient's present incapacity if different):

3. If the condition is a chronic condition or pregnancy, state whether the patient is presently incapacitated and the likely duration and frequency of episodes of incapacity.

4. **Additional treatments:**
   a. If additional treatments will be required for the condition, provide an estimate of the probable number of such treatments.

   If the patient will be absent from work or other daily activities because of treatment, also provide an estimate of the probable number of and interval between such treatments, actual or estimate dates of treatment if known, and period required for recovery if any:

b. If any of these treatments will be provided by another provider of health services (e.g., physical therapist), please state the nature of the treatments:

c. If a regimen of continuing treatment by the patient is required under your supervision, provide a general description of such regimen (e.g., prescription drugs. Physical therapy requiring special equipment):

5. Medical Leave:

a. If medical leave is required for the employee's absence from work (including absences due to pregnancy or a chronic condition), is the employee unable to perform work of any kind?

b. If able to perform some work, is the employee unable to perform any one or more of the essential functions of the employee's job (the employee or the employer should supply you with information about the essential job functions)? If yes, please list the essential functions the employee is unable to form:

c. If neither, a. nor b. applies, is it necessary for the employee to be absent from work for treatment?

Signature of Health Care Provider

Street Address City State ZIP

Telephone Number Date