Montefiore

HR CENTRAL LEAVE ADMINISTRATION OFFICE

NOTIFICATION OF START AND RETURN FROM DISABILITY

(Medical Leave/ Pregnancy Maternity Leave/ Workers Compensation)

FOR OFFICE USE ONLY
(Attach Barcode Label)

INSTRUCTIONS TO MANAGER COMPLETING THIS FORM:

- This form shall be used to notify the **HR Central Leave Administration Office (HR CLAO)**of an Associate's absence lasting more than seven (7) consecutive calendar days due to an Associate's Medical Leave (LMED), Pregnancy Maternity Leave (LMAT) or Workers Compensation (LCOM).
- This form should also be used to notify the HR CLAO of an Associate's return to work dates from such Leaves. Send this complete form to the **HR CLAO.**
- Be advised that an application for disability benefits shall be treated as a request for FMLA due to the Associate's own health condition, providing the *Eligibility Criteria** has been met.
- PART A – Notification of Associate's Leave. Complete sections 1, 2 & 3 when notifying HR of a new Leave. **Nurse Managers should forward this Form to the Nursing Admin. Office for review and completion. The Nursing Admin. Office will send this completed Form to CLAO.**
- **Maintain a copy for your records and use the copy to process the Associate's Extension of Leave or Return to Work sections.**
- PART C – Notification of Associate's Return to Work. Complete sections 4 & 5 when notifying HR CLAO of a return to work date.

PART A - NOTIFICATION OF ASSOCIATE'S LEAVE

SECTION 1. Associate's Information

ASSOCIATE'S NAME: (LAST, FIRST)	ASSOCIATE ID # (EZ time ID):
BARGAINING UNIT: NYSNA ☐ Local 1 ☐ Local 30 ☐ Local 1199 ☐ APTA ☐ Non-Union ☐	DEPARTMENT/DIVISION: SICK TIME AVAILABLE: **(For MDs and House Staff only)** Number of sick days available:

SECTION 2. Leave Details

LAST DAY WORKED:	EFFECTIVE DATE OF THE LEAVE: (FIRST DAY SICK)	EXPECTED DATE OF RETURN:
REASON FOR LEAVE : (CHECK ONE) MATERNITY LEAVE (LMAT) ☐ MEDICAL LEAVE (LMED) ☐ WORKERS COMPENSATION (LCOM) ☐		***FMLA Eligibility Criteria:***Associate must be employed for at least 1 year and have worked at least 1,250 hours excluding paid holiday, vacation, personal and sick days in the preceding 12-month period.

SECTION 3. Manager/Supervisor Information

NAME OF MANAGER/ SUPERVISOR COMPLETING THIS SECTION:
(PRINT CLEARLY: LAST NAME, FIRST NAME)

_____ _____
SIGNATURE

MANAGER/ SUPERVISOR'S PHONE NUMBER: FORM COMPLETION DATE:

HR CENTRAL LEAVE OFFICE	PROCESSED BY:	DATE:

PART B - NOTIFICATION OF ASSOCIATE'S EXTENSION OF LEAVE

SECTION 4. Associate's Information

EXPECTED DATE OF RETURN:	***Healthcare Provider Documentation must be attached in order to process. Failure to submit HPD could result in denial and possible Associate disciplinary action.***

SECTION 5. Manager/Supervisor Information

MANAGER/ SUPERVISOR COMPLETING THIS SECTION: *(PRINT CLEARLY: LAST NAME, FIRST NAME)*	SIGNATURE	PHONE NUMBER: FORM COMPLETION DATE:

HR CENTRAL LEAVE OFFICE	PROCESSED BY:	DATE:

PART C - NOTIFICATION OF ASSOCIATE'S RETURN TO WORK

SECTION 6. Associate's Information

RETURN TO WORK DATE:	CLEARED BY OCCUPATIONAL HEALTH SERVICES? **(OHS) ** YES ☐ **IF 'YES' BOX IS CHECKED, AN OHS CLEARANCE SLIP MUST BE ATTACHED** NO ☐

SECTION 7. Manager/Supervisor Information

MANAGER/ SUPERVISOR COMPLETING THIS SECTION: *(PRINT CLEARLY: LAST NAME, FIRST NAME)*	SIGNATURE	PHONE NUMBER: FORM COMPLETION DATE:

HR CENTRAL LEAVE OFFICE	PROCESSED BY:	DATE:

HRIC: **MMC Current Experience Date:** **MMC Deferred Experience Date**

Comments:

HRIC Case Reviewer: Name: Signature: Date:

CONTACT INFORMATION: TEL # 914-378-6528 FAX # 914 -378-6529, OR SCAN AND EMAIL TO CENTRALLEAVEOFFICE@MONTEFIORE.ORG