Tompkins County Department of Human Resources
125 East Court Street, Ithaca, NY 14850 | P: (607) 274-5526 | F: (607) 274-5401 | www.TompkinsCountyNY.gov
Inclusion through Diversity

MEDICAL LEAVE OF ABSENCE AND DISABILITY PAY REQUEST FORM

Submit this completed form directly to Human Resources in person, through inter-office mail, by secure email to: smurray@tompkins-co.org, or via fax to (607) 274-5401.

Instructions:

This form must be completed in its entirety whenever a Tompkins County Employee requests disability/sick pay for absence due to medical reason(s). **Request forms must be submitted to Human Resources no later than 9:30 a.m. on the Monday following the end of the pay period for which disability/sick is requested.** The medical provider portion of the Claim for Benefits Form must include the nature of the illness/injury, expected length of absence and other pertinent information needed in order for the employee to be deemed eligible for disability/sick pay.

As required by law, any medical leaves of absence determined to be FMLA qualified will be designated as such. Leaves of absence under the FMLA will run concurrent with any other medical leaves of absence (including occupational leaves).

To be completed by Employee (print clearly):

Today's date:		Employee I.D. (if known)	
BASIC INFORMATION			
Employee Last Name: First: Middle:		Phone Number: ( ) - Personal Email:	
Job Title:	Date of Hire: / /	Birth Date: / /	Gender: M F
Street Address:		Supervisor Name:	
P.O. Box:	City:	State:	ZIP Code:

EMPLOYEE REQUEST (Complete the required information and check leave type.)	
Requested Start Date: / /	Anticipated Return To Work Date: / /
Surgery Date: / /	Current Employment Status: ☐ Full-Time ☐ Part-Time

☐ This is a new request	☐ Consecutive Absence
☐ This is an update to an existing request	☐ Intermittent Absence

Please select the reason for your leave request (Human Resources will follow up with you directly for medical or other required documentation as necessary):

- ☐ Work-Related Injury/Illness (INCIDENT REPORT MUST ALSO BE SUBMITTED WITHIN 24 HOURS)
- ☐ My Own Serious Illness/Injury (NOT Work-Related)
- ☐ Serious Illness/Injury of my Child/Parent/Spouse/Domestic Partner
- ☐ Maternity/Paternity/Adoption/Placement of Foster Child/Bonding
- ☐ Military Caregiver ☐ Military Exigency
- ☐ Other (please describe specific circumstances for the request)

Employee: Select correct category
☐ **White Collar, Management, Confidential Employee** When continuous medical leave exceeds three (3) days, employee must submit medical certification. The first three (3) calendar days of any period of inability to work must be covered by other available fringe(s) unless it is caused by scheduled surgery, emergency surgery, or emergency hospitalization. For any additional occurrence of the same illness in the same year, the first day of inability to work must be covered by another available fringe. Refer to Contract for further details. If applicable specify waiting period fringe pay to use for: 1st day: 2nd day: 3rd day:
☐ **Blue Collar Employee** Disability benefits are payable after a seven-day (7) waiting period (or 5 working days) if/when approved. When continuous medical leave exceeds three (3) days, employee must submit medical certification. Disability benefits would be payable to a maximum weekly/daily amount equal to any current maximum imposed by the NYS Disability Benefits Law. Qualifying employee may elect to supplement pay by using available Fringe pay. Refer to contract for further details.
☐ **Corrections/Sheriff Employee** Disability/Sick benefits will be granted from day one (1) when medical provider deems employee unable to work and medical LOA is approved. Employee may use available Sick leave up to maximum of three (3) days prior to needing a doctor's statement. When continuous medical leave exceeds three (3) days, employee must submit medical certification. Refer to Contract for further details.

Substitution of Paid Leave

I understand I am required to utilize all accrued paid leave benefits, including compensatory time, during any medical or other type of leave of absence, until such leave balance(s) are exhausted, prior to going into an unpaid leave status. Approval of disability/sick leave is dependent upon eligibility and the type of leave requested. FMLA leaves run concurrent with other qualifying leaves.

Signature & Acknowledgement

I certify that all of the information I have provided on this form is complete and accurate to the best of my knowledge. I understand that failure to submit required documentation and/or submission of information that is incomplete, misleading, or untruthful, may result in the delay or denial of benefit payments; loss of entitlement to certain benefits; and/or the denial of leave. I understand that I must comply with established leave policies and practices, and the provisions of my collective bargaining agreement, as applicable, as well as follow normal leave procedures for my department.

I hereby claim benefits and certify that for the period covered by this claim I was disabled, and that the foregoing statements, including any accompanying statements, are true and complete. Further, I authorize the disclosure of any medically necessary information between my employer and medical provider.

Employee Signature:	**Date:**
Proxy Signature (if employee unable to complete form):	**Date:**
Department Head/Supervisor Signature & Print Name:	**Date:**
HUMAN RESOURCES USE ONLY	
Authorizing Name (Print) & Date:	

In order to receive disability/sick pay, a new Claim for Benefits form must be completed by your medical provider each pay period. Claim for Benefits forms must be received by Human Resources no later than Monday by 9:15 a.m. following the end of a pay period, to support the Disability/Sick pay (*unless HR confirms differently w/ employee*). Failure to submit a completed Claim for Benefits form will result in your disability/sick pay being delayed and/or denied.

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Claim for Benefits

To Be Completed by Physician ONLY (print clearly)

Tompkins County is eager to work with employees and their physicians to facilitate a return to full-time or part-time work, with or without reasonable accommodation. Your participation in this process is critical and welcome. Your recommendations for a successful and speedy return-to-work will be greatly appreciated. Submit this completed form directly to Human Resources via contact information above. Thank you.

This patient has authorized the release of medical information regarding the following disability claim.

****This form must be submitted prior to an employee being approved to return to work.**
Substitute forms may not be accepted.**

Employee's Full Name:	**Date Employee Out of Work Start Date:**
Physician's Name and field of specialization:	
My diagnosis for the employee is:	
I last examined or treated the employee for that condition on date:	
I expect this condition to continue until date:	

☐ In my opinion, the employee may return to work **without** restriction on **date**: _____

☐ In my opinion, the employee may return to work **with** the restrictions described below on **date**:_____

Restrictions

The employee has the following restrictions (indicate all restrictions on the employee's work activities, including but not limited to, hours of work, specific job duties the employee may perform on a limited basis, repetitive motion restrictions, and specific job duties the employee may not perform at all):

☐ These limitations/restrictions are limited and will continue until (indicate the date each restriction listed in the preceding answer will end):

☐ These limitations/restrictions are permanent.

I will next examine the employee on date:	

My signature indicates that I have read and understand the employee's job description and the limited tasks within the job description and that my findings are based on my medical assessment of this employee's ability to perform the job duties.

Physician Signature	**Date:**

Need more help? Call (607) 274-5530