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) (and/or unpaid FMLA qualified leave of absence). **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)
- ☐ Maternity
- ☐ Serious Illness/Injury of my Child/Parent/Spouse/Domestic Partner (*not eligible for Disability Benefit pay*)
- ☐ Paternity/Adoption/Placement of Foster Child/Bonding (*not eligible for Disability/Sick Benefit pay*)
- ☐ 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 document and submit the Medical Leave of Absence and Disability Pay Request Form to HR (signed by Dept Head/Supervisor). The first three calendar days of inability to work must be covered by another fringe unless it is caused by scheduled or emergency surgery, or emergency hospitalization admission. For any additional occurrence of the same illness in the same year, the first day of inability to work must be covered by another fringe. HR will waive the requirement to submit medical documentation each pay period for major or prolonged medical conditions and critical illness involving inpatient care or continuing treatment by a health care provider (maternity leave, surgical procedures requiring impatient care or continuous treatment). Otherwise, the requirement of every pay period remains. 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**

When continuous medical leave exceeds three (3) days, employee must submit medical document and submit the Medical Leave of Absence and Disability Pay Request Form to HR (signed by Dept Head/Supervisor). Disability benefits are payable after a seven-day waiting period (five working days) if/when approved. 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**

When continuous medical leave exceeds three (3) days, employee must submit medical document and submit the Medical Leave of Absence and Disability Pay Request Form to HR (signed by Dept Head/Supervisor). Disability benefits will be granted from day one (1) when medical provider deems employee unable to work and medical LOA is approved. Employee must submit medical certification before receiving sick/disability benefits. Refer to Contract for further details.

☐ **Sheriff Road Patrol Employee**

When continuous medical leave exceeds three (3) days, employee must submit medical document and submit the Medical Leave of Absence and Disability Pay Request Form to HR (signed by Dept Head/Supervisor). Sick Leave entitlements will be granted from date medical provider deems employee unable to work and HR receives, approves a Medical Leave of Absence and Disability Pay Request Form. One (1) up to a max of three (3) days prior to needing a doctor's statement. For each additional two (2) week period on MLOA, HR must receive a new medical statement before employee receives disability/sick pay. If Disability/Sick Accrual exhaust, employee is required to work six (6) consecutive months before eligible for Disability/Sick LOA again. Vacation and holiday time can't be used as personal sick leave when the employee has exhausted personal leave days or disability/sick time. For family illnesses, the Sheriff or his/her designee, may allow an employe to use time from his/her vacation and/or holiday allotment. Refer to Contract for further details.

Substitution of Paid Leave

I understand I am required to utilize all accrued paid leave benefits per my contract, 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:**
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