Instructions for Family Care Leave of Absence (FCL) Application

New York and New England Bargained for Employees

Please review the Conditions for Leave within the Family Care Leave Guidelines. Your supervisor should review the Conditions for Leave with you before you sign this application.

The minimum duration of any leave period full-time and intermittent FCL requests is three (3) calendar days and the leave must begin on a scheduled workday. Your family member's treating Health Care Provider must complete the attached Health Care Provider's Report which must be submitted with the completed application no later than 25 calendar days from the date the leave begins. The request for Family Care Leave may be denied if the application is submitted without a completed Health Care Provider's Report, if the application and Health Care Provider's Report is received after 25 calendar days from the date the leave began, or the application is incomplete.

If your request for leave is denied, you may request an administrative review of the denial. You will need to provide a copy of the completed application and Health Care Provider's Report, along with supporting documentation. Supporting documentation includes, but is not limited to, a copy of a fax transmittal proving that your application and Health Care Provider's Report was faxed timely, documentation from your family member's treating HCP regarding a processing delay, or documentation of any extenuating circumstances that prevented you from returning the application and Health Care Provider's Report timely.

If you exceed the approved frequency or duration of the leave, you will be required to submit an FCL Recertification form within 25 calendar days from date the frequency or duration was exceeded. The family member's treating Health Care Provider must specifically designate coverage of any time that exceeds the current certification. Failure to submit a recertification form within 25 calendar days may result in a denial and you may be subject to disciplinary action.

Part 1: Employee Information Please provide all required information. If you are not sure of the answer to any of the information requested, for example your net credited service date, ask your supervisor.

Part 2: Request for Leave Please check all that apply. If you are requesting a new FCL or an extension to a previously approved leave, you must provide the requested period of leave. The minimum duration of any leave period full-time and intermittent FCL requests is three (3) calendar days and the leave must begin on a scheduled workday. If you choose to return to work prior to meeting the minimum FCL period of 3 calendar days, your absence will no longer be considered FCL unless the family member you have cared for under FCL has died. The maximum period of FCL is 24 months within a ten-year period. If you exhaust 24 months of leave, you may be eligible for Family Medical Leave Act (FMLA). Leaves over 30 calendar days must be entered into Manager's Self Service (MSS) by the employee's supervisor. If after submitting the leave request, the leave start date needs to be changed, a written statement signed by the employee and supervisor should be faxed to the Leave of Absence Team at (877) 660-2660.

Part 3: Acknowledgements After your supervisor has reviewed the Conditions for Leave with you; you, your supervisor and Director must sign this section. After completing the application, please make a copy and keep it for your records. Mail or fax the supporting medical documentation to the Leave of Absence Team for review.

LOA Administrator
500 Summit Lake Drive, 3rd Floor
Valhalla, NY 10595
Fax: 1-877-660-2660

If you have any questions, please contact 1-800-638-4228 or send an e-mail to verizonleavemanagement@Sedgwickcms.com

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Application for Family Care Leave
(New York and New England Bargained for Employees)

G2518 – FCL
2018

Part 1: Employee Information

Employee Name:	**Employee's NCSD:**
Name of ill Family Member:	
Relationship to Employee:	**Family Member's Date of Birth:**
Employee's Address during Leave:	**Employee's Telephone # during Leave:**
Department Contact:	**Department Contact Telephone #**
Supervisor's Name:	**Director's Name:**

Part 2: Request for Leave (Please check all that apply)

****The minimum duration of any leave period fulltime and intermittent FCL requests is three (3) calendar days and the leave must begin on a scheduled workday.**

☐ Full Time Leave, to begin on ____/____/_____	and to continue through ____/____/_____
☐ Intermittent Leave, to begin on____/____/____	and to continue through ____/____/_____
Frequency _____	Duration _____

*The minimum duration of any leave period full-time and intermittent FCL requests is three (3) calendar days and the leave must begin on a scheduled workday.

Part 3: Acknowledgements

I hereby apply for a Family Care Leave of Absence, in accordance with the Company's leave policy and subject to the conditions contained with this application, including that this leave may be counted against my 12 weeks of FMLA annual entitlement. I have read and understand these conditions. My family member's treating Health Care Provider (HCP) must complete the attached Health Care Provider's Report describing the illness, the anticipated length of the illness and the length of time recommended for Family Care Leave. This must be submitted with this completed application no later than 25 calendar days from the date the leave commences. Please Read Conditions for Leave before Signing.

Employee Signature:	Date:

The above employee has applied for a Family Care Leave Absence. I have reviewed the Verizon Leave Policy and the conditions of the leave, contained with this application, with the employee and confirmed the length of any previous Family Care Leave taken.

The employee's department is responsible to track the frequency and duration of the employee's leave. If employee exceeds the frequency or duration, the employee's department can provide the employee with a FCL Recertification Form (G2518-REC) or the employee can access the form through the eWeb in order to recertify. Completed FCL Recertification form must be submitted to the Leave of Absence Team within 25 calendar days from the date the frequency or duration was exceeded.

Total Period of FCL Previously Taken:

Supervisor Signature:	Date:
Director Signature:	Date:

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Health Care Provider's Report for Family Care Leave of Absence

G2518 – FCL
2018

Section A: (To be completed by the Employee)

In order for your time off to be considered for FCL, it must be specifically designated as FCL qualifying by the treating Health Care Provider (HCP). Once the treating HCP completes the Health Care Provider Report, it must be returned with the application to the Verizon Leave of Absence Team, either by fax: 1-877-660-2660 or mail: LOA Administrator, 500 Summit Lake Drive, 3rd Floor Valhalla, NY 10595. Please be advised that knowingly providing false or inaccurate information in this certification is a violation of the Company's Code of Business Conduct.

Employee Name:

Employee's EMPLID: **Employee's NCSD:**

Name of ill Family Member:

Relationship to Employee: **Family Member's Date of Birth:**

Does the patient require assistance for:

Basic Medical or Personal Needs	☐ **Yes**	☐ **No**	**Transportation**	☐ **Yes**	☐ **No**
Psychological Comfort	☐ **Yes**	☐ **No**	**Safety**	☐ **Yes**	☐ **No**

I hereby certify that the information provided on this Health Care Provider Report is true and accurate.

Employee Signature: _____ Date:

Section B: (To be completed by the Employee's Family Member)

By placing my signature below, I authorize my health care provider to (a) complete this Health Care Provider Report and (b) clarify any information provided on the Health Care Provider's Report that is incomplete or unclear, either verbally or in writing. I hereby certify that the information provided on this Health Care Provider Report is true and accurate.

Family Member Signature: _____ Date:

Section C: (To be completed by the Family Member's Treating Health Care Provider)

Please note: An incomplete Health Care Provider Report will be returned for completion and may result in denial of leave.

1. Describe the medical facts, including a brief statement as to how the medical facts meet the criteria for a Serious Illness. A Serious Illness is defined as an illness, injury, impairment or physical or mental condition that either involves inpatient care in a medical facility or continuing treatment by a health care provider. The term serious illness does not apply to short term conditions for which treatment and recovery are very brief.

2. Prescribed Treatment or Therapy_____
3. Length of time your patient has/will have this condition: From ____/____/____ Through ____/____/____
4. Please provide the following information - check all that apply and complete the corresponding information:
   ☐ **Full Time Leave** - Taken in consecutive, full day increments:
   Dates employee will need to be absent from work: From ____/____/____ Through ____/____/____
   ☐ **Intermittent Leave** – Taken periodically over an extended period of time, with a likely frequency of:
   #____times per (circle one: week, month, year) probable duration of: #____ per (circle one: days, weeks) period of: # ____ (circle one: weeks, months)

Section D: (To be completed by the Family Member's Treating Health Care Provider)

I certify that the above information is true and correct:

Health Care Providers Printed Name: Type of Practice:

Address: Phone #

Health Care Provider's Signature: Date:

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VERIZON
Leave of Absence Team
500 Summit Lake Drive
3rd Floor
Valhalla, NY 10595

Family Care Leave
Fax Cover Sheet

Name: _____

EMPLID: _____

First Day of Leave: _____

Date: _____

Fax #: 1-877-660-2660

From: _____

Pages including cover sheet: _____

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