Print Form

APPLICATION FOR FMLA

(Family and Medical Leave Act of 1993)

City of Bridgeport
Human Resources Dept.
45 Lyon Terrace, Rm. 223
Bridgeport, CT 06604
(203) 576-7224

Employee Name: _____

Title & Department: _____

Current Address: _____

_____

Reason for Leave (check one only):

☐ A) Birth/Adoption of a Child

☐ B) Serious Health Condition (self)

☐ C) Serious Health Condition (parent, spouse, child)

If the reason for leave is for *A) Birth/Adoption of a Child*, please indicate the anticipated start date of the leave:

_____

If the reason for the leave request is for *B) Serious Health Condition (self)* or *C) Serious Health Condition (parent, spouse or child)* it must be accompanied by the attached verifying medical certification completed by a qualified health care provider. _____
Initial

I understand that a failure to return to work at the end of my leave period will be deemed as a voluntary resignation from employment, unless an extension has been granted and approved in writing by the City of Bridgeport, prior to the expiration of the leave. _____
Initial

_____ _____
Employee Signature Date

_____ _____
Department Head Notified Date

_____ _____
Approval—Director Labor Relations/Human Resources Date

A copy of this completed form will be sent to you confirming your FMLA approval.

ACKNOWLEDGEMENT AND MEDICAL RELEASE

(Family and Medical Leave Act of 1993)

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I _____ acknowledge that I have received and reviewed the City of Bridgeport's policy on Family and Medical Leave (FMLA). I have also received an application to apply for FMLA and the medical certification forms to be completed by a qualified health care provider. I understand that I am responsible to follow the guidelines in the City's FMLA policy including but not limited to;

- Properly notifying my supervisor of an FMLA absence,
- Scheduling intermittent FMLA appointments/treatments in a manner not to unduly disrupt the City's operations,
- Providing to my supervisor, if requested, an acceptable doctor's note following an intermittent FMLA absence,
- Making timely payments to maintain group health insurance coverage, if necessary,
- Notifying my supervisor *and* Human Resources prior to my return from an FMLA leave of thirty days or more, and,
- Returning to work at the end of my granted leave period.

_____ _____

Employee Signature Date

Authorization for Release of Health Information

I _____ hereby authorize the use/disclosure of my health information needed to process the above FMLA request. I authorize my physician _____ to disclose my health information to the City of Bridgeport by completing the medical certification forms provided by the City. I understand that the medical information being disclosed will be used by the City of Bridgeport for the purpose of determining if I have a qualifying serious health condition under the Family & Medical Leave Act (FMLA 1993). I understand that I have a right to revoke this authorization at any time by notifying the City of Bridgeport's Benefits Department in writing. I understand that the revocation is only effective after it is received and recorded and that a revocation of this authorization does not disqualify this FMLA leave once it is approved. However, I further understand that the City of Bridgeport may deny or discontinue this FMLA leave if I have revoked this authorization and the City requires the disclosure of more medical information. I understand that any use or disclosure made prior to the revocation under this authorization will not be affected by a revocation. I understand that I am entitled to receive a copy of this authorization.

_____ _____

Patient Signature Date