DEPARTMENT OF CORRECTIONS

REQUEST FOR LEAVE WITH OR WITHOUT PAY

THIS FORM MUST BE COMPLETED AND SIGNED BY EMPLOYEE AND, IF APPLICABLE, CERTIFICATION OF HEALTH CARE PROVIDER MUST ALSO BE COMPLETED AND ATTACHED, BEFORE FORWARDING TO SUPERVISOR FOR APPROVAL. A COPY OF THE REQUESTING EMPLOYEES TALRS PRORATION SCREEN MUST ALSO BE ATTACHED.

PART A GENERAL INFORMATION

NAME____TITLE____

ADDRESS____HOME PHONE____________________________

DIVISION/BUREAU/INSTITUTION____

PART B TYPE OF LEAVE REQUESTED

I HEREBY REQUEST A LEAVE OF ABSENCE DUE TO:

☐FAMILY LEAVE, IF I MEET ELIGIBILITY REQUIREMENTS AS STATED IN HRB 96-01, FOR THE FOLLOWING QUALIFYING EVENT. **COMPLETED CERTIFICATION OF HEALTH CARE PROVIDER MUST BE SUBMITTTED WITH ALL MEDICAL LEAVE REQUESTS.**

☐PERSONAL ILLNESS*

☐PREGNANCY DISABILITY
BIRTH OF CHILD
INDICATE DATE OF BIRTH__________________

☐PLACEMENT OF A CHILD DUE TO ADOPTION OR FOSTER CARE - **DATE**_____________________

☐CHILD CARE

☐SERIOUS HEALTH CONDITION OF FAMILY MEMBER
RELATIONSHIP____________________________

☐LEAVE OF ABSENCE WITH WORKERS COMPENSATION

☐SLI/ON THE JOB INJURY
ATTACH COMPLETED ACCIDENT REPORT (RM-2) SUBMITTED NO LATER THAN THE 2ND DAY AFTER THE INJURY OR ILLNESS OCCURRED, IN TRIPLICATE, TO THE PERSONNEL OFFICE.

☐VOLUNTARY FURLOUGH

☐VOLUNTARY FURLOUGH EXTENSION

☐MILITARY - **ATTACH COPY OF ORDERS**

☐OTHER___________________________

☐**INITIAL REQUEST** ☐**EXTENSION REQUEST**

DOES YOUR SPOUSE WORK FOR THE STATE OF NJ?
☐**YES** ☐**NO IF YES, INDICATE NAME & DEPARTMENT** ____

I HEREBY REQUEST THAT THIS LEAVE BE ☐ **WITH PAY** ☐ **WITHOUT PAY.**

Any employee on leave due to stress or psychological and/or related conditions must be cleared by a psychiatrist or licensed clinical psychologist prior to returning to work. Questions regarding this policy may be directed to your HR Manager.

SIGNATURE____ **DATE**______________________________

PART C DURATION OF LEAVE

TO BE COMPLETED FOR ALL TYPES OF LEAVE REQUESTS

FULL TIME LEAVE FROM______________________**THROUGH**______________________

☐REDUCED OR INTERMITTENT LEAVE - **ATTACH DETAILED SCHEDULE**

DEPARTMENT POLICY REQUIRES THE USE OF ALL EARNED SICK LEAVE PRIOR TO RECEIVING A LEAVE WITHOUT PAY.

DO YOU WISH YOUR EARNED VACATION TIME TO BE USED? ☐YES ☐NO

DO YOU WISH YOUR EARNED COMP TIME TO BE USED? ☐YES ☐NO (WILL NOT REDUCE FAMILY LEAVE ENTITLEMENT)

DO YOU WISH YOUR EARNED AL TIME TO BE USED? ☐YES ☐NO

PART D VOLUNTARY FURLOUGH/FURLOUGH EXTENSION LEAVE

REASON FOR REQUEST____

EMPLOYEE: READ CAREFULLY AND SIGN

I CERTIFY THAT I WILL NOT USE VOLUNTARY FURLOUGH FOR ANY OF THE FOLLOWING PURPOSES: SICK LEAVE, AS A LEAVE WITHOUT PAY DUE TO DISABILITY, OR TO SEEK ALTERNATIVE EMPLOYMENT. I UNDERSTAND THAT IF I USE VOLUNTARY FURLOUGH OR FURLOUGH EXTENSION LEAVE FOR A PURPOSE COVERED BY THE FEDERAL FAMILY MEDICAL LEAVE ACT (FMLA) OR THE STATE FAMILY LEAVE ACT (FLA) WHICH DEEMS ME ELIGIBLE FOR COVERAGE UNDER FMLA OR FLA, THE VOLUNTARY FURLOUGH OR EXTENSION SHALL BE RECORDED AS FMLA LEAVE, FLA LEAVE OR BOTH.

NOTE: FURLOUGH EXTENSION LEAVES (MORE THAN 30 AND UP TO 60 ADDITIONAL DAYS IN A CALENDAR YEAR) MUST BE TAKEN IN BLOCKS OF 10 DAYS, WHICH NEED NOT BE CONSECUTIVE, AND MAY ONLY BE USED FOR EDUCATION OR FAMILY CARE NEEDS.

☐Yes ☐No WHILE ON FURLOUGH EXTENSION LEAVE I WISH TO DISCONTINUE ALL OR PART OF MY HEALTH BENEFITS PACKAGE.

SIGNATURE____**DATE**_____________________________________

PART E AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION PURSUANT TO THE HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT 45 C.F.R. 164.508

I,_________________________________DO HEREBY CONSENT AND AUTHORIZE_________________________________
(i.e. Name of Treating Doctor)
LOCATED AT ____TO RELEASE MY PROTECTED HEALTH INFORMATION

TO________________________________ REPRESENTING THE STATE OF NJ, DEPARTMENT OF CORRECTIONS.
(Human Resources Representative)
DISCLOSURE INCLUDES INFORMATION FROM MY CLINICAL RECORDS PERTAINING TO THE REASONS FOR THIS LEAVE REQUEST, INCLUDING A TREATMENT SUMMARY. I UNDERSTAND THAT THE PURPOSE OF THIS DISCLOSURE IS IN ACCORDANCE WITH MY REQUEST FOR A LEAVE OF ABSENCE AND TO DETERMINE WHETHER I AM CAPABLE OF PERFORMING MY EMPLOYMENT DUTIES. I ALSO UNDERSTAND THAT THIS CONSENT IS REVOCABLE AT ANY TIME UPON WRITTEN REQUEST AND THAT IT WILL REMAIN IN FORCE FOR A PERIOD OF 180 DAYS FROM THE DATE SIGNED, UNLESS I SPECIFY OTHERWISE, IN ORDER TO EFFECTUATE THE PURPOSE FOR WHICH IT IS GIVEN. I UNDERSTAND THAT THERE MAY NOT BE CONDITIONS ON TREATMENT, PAYMENT, ENROLLMENT OR ELIGIBILITY FOR BENEFITS WHETHER OR NOT I SIGN THIS AUTHORIZATION. I UNDERSTAND THE POTENTIAL FOR INFORMATION DISCLOSED PURSUANT TO THIS AUTHORIZATION TO BE SUBJECT TO REDISCLOSURE BY THE RECIPIENT AND NO LONGER PROTECTED BY 45 C.F.R. 164.508

SIGNATURE______________________________________**DATE**_____________________________________

PART F MANAGEMENT CERTIFICATION

FOR CENTRAL OFFICE USE

______________________________________ ☐ APPROVED
SUPERVISOR/DEPARTMENT HEAD DATE ☐ DISAPPROVED

______________________________________ ☐ APPROVED
DIRECTOR DATE ☐ DISAPPROVED

______________________________________ ☐ APPROVED
ASSISTANT COMMISSIONER/ CHIEF OF STAFF/ COMMISSIONER DATE ☐ DISAPPROVED

FOR INSTITUTION USE

______________________________________ ☐ APPROVED
SUPERVISOR/DEPT HEAD DATE ☐DISAPPROVED

______________________________________ ☐ APPROVED
ADMINISTRATOR /SUPT DATE ☐DISAPPROVED

Revised 10/04