

**NEW YORK CITY HEALTH AND HOSPITALS CORPORATION  
Request for Leave or Approved Absence**

1. Print or Type Full Name		2. TK ID		3. Date of Request																																															
4. Facility or Central Office Division		5. Title		6. Original Date of Appointment																																															
7. Work Location		8. <b>Type of Leave/Absence</b>																																																	
Check appropriate boxes and enter date and time below <table border="1" style="width:100%; border-collapse: collapse;"> <thead> <tr> <th rowspan="2"></th> <th colspan="2">Date</th> <th colspan="2">Time</th> <th rowspan="2">Total Hours</th> </tr> <tr> <th>From</th> <th>To</th> <th>From</th> <th>To</th> </tr> </thead> <tbody> <tr> <td><input type="checkbox"/> Annual Leave</td> <td></td> <td></td> <td></td> <td></td> <td></td> </tr> <tr> <td><input type="checkbox"/> Sick Leave - (Must submit physician's note if sick leave exceeds 3 days.)</td> <td></td> <td></td> <td></td> <td></td> <td></td> </tr> <tr> <td><input type="checkbox"/> Personal Leave Day (NYSNA only)</td> <td></td> <td></td> <td></td> <td></td> <td></td> </tr> <tr> <td><input type="checkbox"/> Compensatory Time Off</td> <td></td> <td></td> <td></td> <td></td> <td></td> </tr> <tr> <td><input type="checkbox"/> Other Paid Absence (Complete Box 10 Below)</td> <td></td> <td></td> <td></td> <td></td> <td></td> </tr> <tr> <td><input type="checkbox"/> Leave Without Pay</td> <td></td> <td></td> <td></td> <td></td> <td></td> </tr> </tbody> </table>			Date		Time		Total Hours	From	To	From	To	<input type="checkbox"/> Annual Leave						<input type="checkbox"/> Sick Leave - (Must submit physician's note if sick leave exceeds 3 days.)						<input type="checkbox"/> Personal Leave Day (NYSNA only)						<input type="checkbox"/> Compensatory Time Off						<input type="checkbox"/> Other Paid Absence (Complete Box 10 Below)						<input type="checkbox"/> Leave Without Pay						<b>Family and Medical Leave</b>  Annual leave, sick leave or leave without pay will be used under the Family and Medical Leave Act of 1993 (FMLA) for: <ul style="list-style-type: none"> <li>▪ Birth/Adoption/Foster Care</li> <li>▪ Serious health condition of spouse, son, daughter or parent</li> <li>▪ Serious health condition of self</li> <li>▪ Military Family Leave                         <ul style="list-style-type: none"> <li>a) Service Member Family Leave</li> <li>b) Qualifying Exigency Leave</li> </ul> </li> </ul> Contact your Human Resources office to obtain additional information about your entitlements and responsibilities under the FMLA. Medical certification of a serious health condition is required.			
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10. Remarks																																																			
11. I certify that the leave/absence requested above is for the purposes indicated. I understand that I must comply with procedures for requesting leave/approved absence, and provide additional documentation, including medical certification, if required.																																																			
11a. Employee Signature			11b. Date Signed																																																
12a. Supervisor <input type="checkbox"/> Scheduled <input type="checkbox"/> Unscheduled			12b. <input type="checkbox"/> Approved <input type="checkbox"/> Disapproved																																																
13a. Signature of Supervisor			13b. Date Signed																																																

**Spaces below for Timekeeping Office Use Only**

	Balance as of above date	Debit – Hours	Balance - Hours
<b>Annual Leave</b>			
<b>Sick Leave</b>			

## **INSTRUCTIONS FOR COMPLETING SR 70**

- 1) NAME: Enter your name
- 2) TK ID: Enter your timekeeping ID number as it appears in the TK ID box on your timesheet, below your name.
- 3) Date of Request: Enter date you are making request
- 4) Facility or Central Office Division: Enter the name of your facility.
- 5) Title: Enter your job title
- 6) Original Date of Appointment: Enter your original date of appointment (ODA)
- 7) Work Location: Enter the cost center or name of the unit where you work (i.e., Telemetry 12 N)
- 8) Type of Leave/Reason for Absence: In this section, you must choose the type of leave you are requesting. Enter the dates and time periods needed, and add the total number of hours requested.
  - **Annual leave:** Check-off annual leave when requesting time for vacation, personal business, religious observance, or to care for sick family members when provisions of family sick leave (ATLS code 57) do not apply.
  - **Sick Leave:** To be used for your own personal illness or medical appointment. No more than three sick days per timekeeping year for that of a family member, subject to supervisory approval. (Prevailing rate employees are not covered by this provision.) The HHC 996 must be used for absences related to job related illness or injury covered by Worker's Compensation.
  - **Personal Day (PLD) NYSNA members only:** Employees in titles covered by the New York State Nurse's Association contract receive three PLD's per year. (ATLS code 64) Not valid for any other use.
  - **Compensatory Time Off:** To use compensatory time credited for overtime worked as a Group 12 employee.
  - **Other Paid Absence (specify in Box 10 Remarks):** Examples include jury duty, death in family (bereavement) leave, separation leave, retirement and floating holiday.
  - **Leave Without Pay:** To be requested when appropriate paid leave balance is exhausted.
- 9) Purpose: In the Purpose section, you must check-off the box that best explains why you are taking leave. There are four choices listed explaining the reason for the requested leave. You are no longer required to indicate the nature or other details of your illness or that of a family member on this form. However, you are still required to provide documentation of illness from a medical provider, if absent more than three days, and may be required to provide detailed documentation to Human Resources or Occupational Health Services.
  - Vacation/Annual Leave Used for Personal Reasons: to be used with requests for annual leave
  - Illness/Injury/incapacitation of requesting employee (Use HHC 996 if Worker's Compensation): to request sick leave, or if sick leave balances are exhausted, annual leave, compensatory time or leave without pay
  - Medical/dental/optical examination of requesting employee: to request leave for these purposes, the employee should request sick leave, if sick leave balances are exhausted, annual leave, compensatory time or leave without pay
  - Care of family member, including medical/dental/optical examination of family member: to be used with either annual or sick leave
- 10) Remarks: Specify type of "other" paid absence.
- 11a) Employee signature
- 11b) Date Signed
- 12a) Supervisor indicates if request was scheduled in advance or unscheduled.
- 12b) Supervisor indicates if request is approved or denied.
- 13a) Signature of Supervisor
- 13b) Date Supervisor Signed

**Family and Medical Leave Act (FMLA):** The federal Family and Medical Leave Act (FMLA) entitles eligible HHC employees to up to 12 weeks of leave in a 12-month period for child care upon the birth, adoption or foster care placement of a child; and for the serious health condition of the employee or covered family members. In addition, eligible employees with family members in the military are entitled to two types of Military Family Leave. *Service member Family Leave* entitles eligible employees to up to 26 weeks of unpaid leave during a single twelve (12)-month period to care for an injured member of the Armed Forces. *Qualifying Exigency Leave* entitles eligible employees to up to 12 weeks of leave during a single twelve (12)-month period to handle any qualifying exigencies (situations requiring immediate attention) as a result of a qualified family members' military deployment. Qualified family members include spouses, sons, daughters, parents, or next of kin who are on active duty in the Armed Forces or who have been notified of an impending call to active duty. The FMLA does not provide paid leave. Contact your Human Resources office if you are out more than three consecutive workdays. Approved paid or unpaid leave for FMLA eligible events will be designated FMLA leave.