Paid Family Leave Program

Request For Paid Family Leave (Form PFL-1)

PART A - EMPLOYEE INFORMATION (to be completed by employee)

1. **Employee's legal name** (first name, middle initial, last name)

2. **Other last names, if any, under which employee has worked**

3. **Employee's mailing address**

Mailing address

City, state, zip code, country (if not U.S.A.)

4. **Employee's Social Security number (or TIN)** ☐☐☐ - ☐☐ - ☐☐☐☐

5. **Employee's date of birth** (MM/DD/YYYY) ☐☐ / ☐☐ / ☐☐☐☐

6. **Employee's county of residence**

7. **Employee's primary telephone number** (☐☐☐) ☐☐☐ - ☐☐☐☐

8. **Employee's email address**

9. **Employee's gender** ◯ Male ◯ Female

10. **Employee's preferred language** ◯ English ◯ Español ◯ Русский ◯ Polski ◯ 中文 ◯ Italiano ◯ Kreyòl ayisyen ◯ 한국어 ◯ Other

11. **Employee's ethnicity and race** Optional, for purposes of health demographic only. (U.S. Centers for Disease Control and Prevention (CDC) code set, version 1.0.)

Is employee of Hispanic, Latino/a, or Spanish origin?
(One or more categories may be selected.)

- ☐ Mexican
- ☐ Mexican American
- ☐ Chicano/a
- ☐ Puerto Rican
- ☐ Dominican
- ☐ Cuban
- ☐ Another Hispanic, Latino/a, or Spanish origin
- ☐ Not of Hispanic, Latino/a, or Spanish origin
- ☐ Unknown

What is employee's race?
(One or more categories may be selected.)

- ☐ American Indian or Alaska Native
- ☐ Black or African American
- ☐ Asian Indian
- ☐ Chinese
- ☐ Filipino
- ☐ Japanese
- ☐ Korean
- ☐ Vietnamese
- ☐ Other Asian
- ☐ White
- ☐ Native Hawaiian
- ☐ Guamanian or Chamorro
- ☐ Samoan
- ☐ Other Pacific Islander
- ☐ Other race

Paid Family Leave (PFL) Request

12. **Reason for PFL request:** ◯ Bond with child ◯ Care for family member ◯ Military qualifying event

13. **The family member is employee's:** ◯ Child ◯ Spouse ◯ Domestic partner ◯ Parent ◯ Parent-in-law ◯ Grandparent ◯ Grandchild

14a. **Estimated PFL start date** (MM/DD/YYYY) ☐☐ / ☐☐ / ☐☐☐☐

14b. **If providing less than 30 days advance notice from the date in 14a, please explain:**

15. **Estimated PFL end date** (MM/DD/YYYY) ☐☐ / ☐☐ / ☐☐☐☐

16a. **Will PFL be for a continuous period of time and/or periodic?** ☐ Continous ☐ Periodic

16b. **Identify dates PFL will be taken:**

16c. **Are these dates estimated?** ◯ Yes ◯ No

17. **Is this form being pre-filed?** ◯ Yes ◯ No

Employment Information

18. **Business name**

19. **Employee's date of hire** (MM/DD/YYYY) ☐☐ / ☐☐ / ☐☐☐☐

20. **Employee's work location**

Street address

City, state, zip code, country (if not U.S.A.)

21. **Employee's average weekly wage** $ ☐☐☐☐ . ☐☐

This data will be requested of both employee and employer

22. **Employer's telephone number** (☐☐☐) ☐☐☐ - ☐☐☐☐

23a. **Does employee have more than one employer?** ◯ Yes ◯ No

23b. **If yes, is employee taking PFL from the other employer?** ◯ Yes ◯ No

24. **Is employee currently receiving Workers' Compensation Lost Wage Benefits?** ◯ Yes ◯ No

Disclosure statement: Information regarding PFL benefits received by the employee, such as payments received and types of leave, will be provided to the employer.

Declaration and signature

Any person who knowingly and with intent to defraud presents, causes to be presented, or prepares with knowledge or belief that it will be presented to or by an insurer, or self-insurer, any information containing any false material statement or conceals any material fact shall be guilty of a crime and subject to substantial fines and imprisonment.

I am hereby making a request for paid family leave benefits under the NYS Workers' Compensation Law. My signature affirms that the information I am providing is true and accurate to the best of my knowledge and belief.

Employee's signature

Date signed (MM/DD/YYYY) ☐☐ / ☐☐ / ☐☐☐☐

If you need assistance, please call (844) 337-6303

www.ny.gov/PaidFamilyLeave

TO BE COMPLETED BY THE EMPLOYEE

Employee's name
(first name, middle initial, last name) _____

Last 4 digits of employee's Social Security number (or TIN) ☐☐☐☐

PART B - EMPLOYER INFORMATION (to be completed by the employer)

1. Business name and mailing address

_____
Business name

_____
Mailing address

_____
City, state, zip code, country (if not U.S.A.)

2. Employer's FEIN
☐☐ - ☐☐☐☐☐☐☐

3. Employer's NAICS Industry Code
Codes are available at:
https://www.naics.com/naics-drilldown-table/
☐☐☐☐☐☐

4. Employer's contact name

_____

5. Employer's contact telephone number
(☐☐☐) ☐☐☐ - ☐☐☐☐

6. Employer's contact email address

_____

7. Employee's date of hire (MM/DD/YYYY)
☐☐ / ☐☐ / ☐☐☐☐

8. Employee's occupation Codes are available at:
www.bls.gov/soc/2010/soc_alph.htm
☐☐ - ☐☐☐

9. Enter the last 8 weeks of wages for the employee

Week no.	Week ending date (MM/DD/YYYY)	Number of days worked	Gross amount paid	Week no.	Week ending date (MM/DD/YYYY)	Number of days worked	Gross amount paid
1				5			
2				6			
3				7			
4				8			

10. Employee's average weekly wage $ ☐☐☐☐ . ☐☐

11. If employee received or will receive full wages while on PFL, will employer be requesting reimbursement? ◯ Yes ◯ No

12a. In the preceding 52 weeks has the employee taken leave for: ◯ Disability ◯ PFL ◯ Both Disability and PFL ◯ None

12b. Enter the total number of weeks and days taken for both Disability and PFL in the last 52 weeks:

Disability: _____ Weeks _____ Days

Please provide specific dates for Disability:

PFL: _____ Weeks _____ Days

Please provide specific dates for PFL:

13. Is the employee taking Family Medical Leave Act (FMLA) concurrently with PFL? ◯ Yes ◯ No

PFL Insurance Carrier

14. PFL insurance carrier's name and mailing address

_____
PFL insurance carrier's name

_____
Mailing address

_____
City, state, zip code, country (if not U.S.A.)

15. PFL insurance carrier's telephone number
(☐☐☐) ☐☐☐ - ☐☐☐☐

16. PFL policy number

_____

Declaration and signature

Any person who knowingly and with intent to defraud presents, causes to be presented, or prepares with knowledge or belief that it will be presented to or by an insurer, or self-insurer, any information containing any false material statement or conceals any material fact shall be guilty of a crime and subject to substantial fines and imprisonment.

I am the person authorized to sign as the employer of the employee requesting PFL. My signature affirms that to the best of my knowledge and belief, the information I have provided is true and accurate.

_____ Employer's authorized signature

_____ Title

☐☐ / ☐☐ / ☐☐☐☐ Date signed (MM/DD/YYYY)

Paid Family Leave Program

Request For Paid Family Leave Form Instructions

Under New York State Law, qualified employees are entitled to Paid Family Leave (PFL) benefits to:

- Bond with a newborn, a newly adopted or fostered child
- Care for a family member with a serious health condition
- Care for family members as needed due to another family member's active military duty or impending active duty

The following are instructions for how to request Paid Family Leave.

Request For Paid Family Leave (Form PFL-1)

To request PFL, the employee requesting PFL completes all items in Part A of the *Request For Paid Family Leave (Form PFL-1)*. All items on the form are required unless noted as optional. The employee then provides the form and instructions to the employer to complete Part B.

The employer completes Part B of the *Request For Paid Family Leave (Form PFL-1)* and returns it to the employee within three days.

Additional forms are required depending on the type of PFL leave being requested. The employee requesting leave is responsible for the completion of these forms.

Reason for Paid Family Leave	Required Additional Form
Bond with a newborn, a newly adopted child or a foster child	*Bonding Certification (Form PFL-2)*
*Care for a family member with a serious health condition	*Health Care Provider Certification For Care Of Family Member With Serious Health Condition (Form PFL-4)*
Time off due to a family member's active military duty or impending active duty	*Military Qualifying Event (Form PFL-5)*

* If the employee is taking PFL to care for a family member with a serious health condition, the care recipient completes the *Release Of Personal Health Information Under The Paid Family Leave Law (Form PFL-3)*. This form must be provided to the care recipient's health care provider along with the *Health Care Provider Certification For Care Of Family Member With Serious Health Condition (Form PFL-4)*. The health care provider completes the *Health Care Provider Certification For Care Of Family Member With Serious Health Condition (Form PFL-4)* and returns it to the employee requesting PFL.

The employee submits the completed *Request For Paid Family Leave (Form PFL-1)* with the required additional form to the employer's PFL insurance carrier listed on Part B of *Request For Paid Family Leave (Form PFL-1)*. The employee should retain a copy of each submitted form for his or her records.

Note: Please use the following format for dates: MM/DD/YYYY.

See next page for instructions for Part A of the *Request For Paid Family Leave (Form PFL-1)*.

PART A - EMPLOYEE INFORMATION (to be completed by the employee)

The employee requesting PFL must complete all required information.

Question 2: Indicate if employee has used another last name, either professionally or personally, in the past year.

Question 4: Social Security number or TIN: An employee who has a Taxpayer Identification Number (TIN) should enter his or her TIN.

Paid Family Leave Request

Questions 12 & 13: Indicate the reason for the PFL request and the employee's relationship to the family member.

Questions 14a & 15: The employee must provide the start and end dates of the requested PFL. These dates should be the actual dates that the PFL will begin and end. If uncertain, estimate the start and end dates.

Question 14b: If the employee is submitting the PFL request to his or her employer with less than 30 days' advance notice from the start date of the PFL, the employee must explain why 30 days' notice could not be given. If the explanation will not fit in the space provided on the form, enter "See Attached" and add an attachment with the explanation. Be sure to include the employee's full name and last four digits of his or her Social Security number (or TIN) at the top of the attachment.

Question 16b: Enter the dates PFL will be taken. Please be as specific as possible. If the dates are unknown or estimated, the PFL carrier may require you to submit a request for payment **after** the PFL day is taken. Payment will be due as soon as possible but in no event more than 18 days from the date of the request for payment.

If the explanation will not fit in the space provided on the form, enter "See Attached" and add an attachment with the explanation. Be sure to include the employee's full name and last four digits of his or her Social Security number (or TIN) at the top of the attachment.

Question 17: Indicate if the employee is pre-filing his or her PFL request. Pre-filing is defined as submitting the application in advance of an upcoming qualifying event, with certain required information missing due to the information being unknown at the time of the filing. If pre-filing is permitted by the carrier or self-insured employer, the missing information must be supplied as soon as it is known. Benefits cannot be determined until all of the required information is provided.

The PFL insurance carrier or self-insured employer will provide the employee a notice within five days which 1) states the claim is pending; 2) identifies what information is missing; 3) instructs how to submit the missing information. Once all information is supplied, the PFL insurance carrier or self-insured employer has 18 days to pay or deny the claim.

If the carrier or self-insured employer does not permit pre-filing, the carrier or self-insured employer must return the Request for Paid Family Leave within five days to the employee with an explanation that the claim should be re-submitted when all information is available.

Employment Information

Question 18: Enter the employer's business name. If known, provide the full legal name of the business (e.g., "Walgreen Company" instead of "Walgreens"). Enter the address of the employee's work location.

Question 19: Enter the date of hire to the best of the employee's recollection. If it has been more than a year since the date of hire, entering the year in which employment started is sufficient.

Question 21: Enter the best estimate of the employee's average gross weekly wage, include only the wages earned from the employer listed on this request form. **The gross weekly wage is the employee's total weekly pay — including overtime, tips, bonuses and commissions — before any deductions are made by the employer,** such as federal and state taxes. If the employer is not able to supply this information, the employee can calculate his or her gross weekly wage as follows:

Step 1: Add all gross wages received (before any deductions) over the last eight weeks prior to the start of PFL, including overtime and tips earned. *(See Step 3 for instructions for calculating bonuses and/or commissions.)*

Step 2: Divide the gross wages calculated in step one by eight (or the number of weeks worked if less than eight) to calculate the average weekly wage.

Step 3: If the employee received bonuses and/or commissions during the 52 weeks preceding PFL, add the prorated weekly amount to the average weekly wage. To determine the prorated weekly amount, add all bonuses/commissions earned in the preceding 52 weeks and then divide by 52.

Example of a gross weekly wage calculation:

Week 1 - Gross wage including overtime	$550
Week 2 - Gross wage	$500
Week 3 - Gross wage	$500
Week 4 - Gross wage	$500
Week 5 - Gross wage	$500
Week 6 - Gross wage	$500
Week 7 - Gross wage, including overtime	$600
Week 8 - Gross wage, including overtime	+ $550
Total:	**$4,200**
Divide by 8:	÷ 8
Average Weekly Wage =	**$525**

Bonus earned in preceding 52 weeks:	*$2,600*
Divide by 52:	*÷ 52*
Prorated Weekly Bonus =	*$50*

Average Weekly Wage =	**$525**
Prorated Weekly Bonus =	**+ $50**
Average Weekly Wage (including bonus) =	**$575**

Please note that the employer is also required to provide this information in Part B of the *Request For Paid Family Leave (Form PFL-1)*.

Question 23b: If the employee has more than one employer, indicate whether the employee is taking PFL from the other employer.

Employee enters name and last four digits of his or her Social Security number (or TIN) at the top of page 2.
Employee signs and dates, before giving this form to his or her employer to complete Part B.

See next page for Part B of the *Request For Paid Family Leave (Form PFL-1)*.

PART B - EMPLOYER INFORMATION (to be completed by the employee's employer)

The employer of the employee requesting PFL must complete all information in Part B.

Employer Information

Question 1: Enter the business' full legal name and address.

Question 2: If a Social Security number is used for the Federal Employer Identification Number (FEIN), enter the Social Security number.

Question 3: The employer industry code can be found at: **https://www.naics.com/naics-drilldown-table/**

Question 4, 5 & 6: Enter the name, phone number and email address of a contact person at the employer who can answer questions regarding this form.

Question 8: The employee occupation code can be found at: **www.bls.gov/soc/2010/soc_alph.htm**

Question 9: Enter the wages earned by the employee during the last eight weeks preceding the PFL start date. The gross amount paid is the employee's gross weekly pay, including any overtime and tips earned for that week, plus the weekly prorated amount of any bonus or commission received during the preceding 52 weeks. *(For detailed steps, see Question 19 on page 2 of the instructions.)*

Question 10: Calculate the gross average weekly wage by adding up the gross amounts paid, listed in Question 9, and then divide by eight (or number of weeks worked if less than eight).

Question 12a: If the answer is "none," enter a "0" for total weeks and days.

Question 12b: The maximum number of weeks available for Disability and PFL in any 52-week period is 26 weeks. Specify the total number of weeks, as well as the number of additional days if the leave includes a partial week, taken for Disability and PFL during the preceding 52 weeks.

PFL Insurance Carrier

Enter the Paid Family Leave disability/PFL insurance carrier's name, address and PFL policy number. If this employer is self-insured, enter the name and address of where the PFL request should be submitted for processing.

Employer signs and dates, and then returns to the employee requesting PFL within three business days.

See additional instructions for required forms relevant to the type of PFL leave being requested.

Paid Family Leave Program

Request for Paid Family Leave
Bonding Certification (Form PFL-2)

TO BE COMPLETED BY THE EMPLOYEE

Employee's name (first name, middle initial, last name) _____

Last 4 digits of employee's Social Security number (or TIN) ☐☐☐☐

BONDING CERTIFICATION (to be completed by the employee)

1. **Child's legal name** (first name, middle initial, last name)

_____

2. **Child's date of birth** (MM/DD/YYYY) ☐☐ / ☐☐ / ☐☐☐☐

3. **Child's address**

_____

Mailing address

_____

City, state, zip code, country (if not U.S.A.)

4. **Child's gender** ◯ Male ◯ Female

5. **Child is employee's:** ◯ Biological child ◯ Stepchild ◯ Foster child ◯ Adopted child ◯ Legal ward ◯ Domestic partner's child

6. **Select one of the following and attach a copy of the document required as evidence of the relationship.**
(Do not send the original document. It will not be returned.)

Parent of newborn infant:

Birth mother:

- ◯ Health care provider certification of pregnancy (include expected due date AND mother's name); OR
- ◯ Health care provider certification of birth (include date of birth of infant AND mother's name); OR
- ◯ Infant's birth certificate

Other parent:

- ◯ Voluntary acknowledgment of paternity; OR
- ◯ Court order of filiation; OR
- ◯ Birth mother documents (see above) PLUS one of the following:
  - ◯ Marriage certificate; OR
  - ◯ Certificate of civil union; OR
  - ◯ Certificate of domestic partnership
- ◯ OR; Other documentation of parental relationship

NOTE: If the second parent is named on the birth certificate, a copy of the birth certificate is sufficient.

Foster parent:

- ◯ Letter of foster care placement issued by county or city department of Social Services or authorized voluntary foster care agency

Adoptive parent:

- ◯ Court document finalizing adoption
- ◯ Documentation in furtherance of adoption

Date of foster care or adoption placement if applicable (MM/DD/YYYY) ☐☐ / ☐☐ / ☐☐☐☐

Declaration and signature

Any person who knowingly and with intent to defraud presents, causes to be presented, or prepares with knowledge or belief that it will be presented to or by an insurer, or self-insurer, any information containing any false material statement or conceals any material fact shall be guilty of a crime and subject to substantial fines and imprisonment.

I am hereby making a request for paid family leave benefits under the NYS Workers' Compensation Law. My signature affirms that the information I am providing is true and accurate to the best of my knowledge and belief.

_____ ☐☐ / ☐☐ / ☐☐☐☐

Employee's signature — Date signed (MM/DD/YYYY)

Request For Paid Family Leave
Bonding Certification (Form PFL-2)

If the employee is requesting PFL to bond with a newborn, a newly adopted child or a foster child, the employee must submit the *Bonding Certification (Form PFL-2)* with the *Request For Paid Family Leave (Form PFL-1)*.

BONDING CERTIFICATION (to be completed by the employee)

The employee requesting PFL must complete all applicable requested information.

Employee enters name and last four digits of his or her Social Security (or TIN) number at the top.

Enter the child's information, and indicate the child's relationship to the employee.

Questions 1, 2 & 4: If the form is submitted to the PFL insurance carrier prior to the birth of a child, this is considered pre-filing. The employee is then required to contact the PFL insurance carrier and provide the required documentation of the child's birth. The PFL carrier will tell the employee how and when to provide the required additional documentation.

There may be instances where PFL can be taken before the adoption is finalized. For example, the employee may be required to appear in court or travel to another country as part of the adoption process. The employee should include documentation to show that the PFL is necessary to further the adoption.

Question 6: See chart below for documentation details. Unless specified, do not send the original documents.

Bonding Form/Certification	Description
Birth mother: Health care provider certification of pregnancy	An **original** letter obtained from the birth mother's health care provider that certifies pregnancy. It should include the mother's name and the expected due date.
Health care provider certification of birth	An **original** letter obtained from the birth mother's health care provider that includes the mother's name and infant's date of birth.
Birth Certificate	A **copy** of the certificate issued by the city or county office in which the infant is born.
Voluntary Acknowledgment of Paternity (Form LDSS-4418)	A **copy** of the form that establishes legal fatherhood when the parents are unmarried. Completed by both mother and father. For more information, see childsupport.ny.gov/dcse/aop_howto.html
Court Order of Filiation	A **copy** of the order from the family court that names the father of a child. Establishes legal fatherhood when the parents are unmarried. Completed by both mother and father. For more information, visit childsupport.ny.gov/dcse/aop_howto.html
Marriage Certificate	A **copy** of the official statement issued by the town or city clerk from which the marriage certificate was issued.
Civil union/domestic partner's documentation	A **copy** of the certificate of civil union or domestic partnership.
Foster care placement letter	A **copy** of the letter of foster care placement issued by the county or city department of social services or authorized voluntary foster care agency.
Court documents of adoption	A **copy** of the court document finalizing adoption or documentation in furtherance or court order finalizing adoption.
Other documentation	Other documentation of parental relationship may be accepted if none of the others listed apply.

Employee signs and dates.

Paid Family Leave Program

Request for Paid Family Leave
Release Of Personal Health Information (PHI) Under The Paid Family Leave Law (Form PFL-3)

TO PERMIT THE RELEASE OF PERSONAL HEALTH INFORMATION BY THE HEALTH CARE PROVIDER FOR A FAMILY MEMBER WITH A SERIOUS HEALTH CONDITION (to be signed by the health care recipient)

I, _____, authorize my health care provider listed on this form to release my personal
Care recipient's name

health information to _____ and his or her employer's
Employee's name

PFL insurance carrier _____.
PFL insurance carrier's name

Records Subject to Release: This form gives the health care provider listed permission to include information from your health care records on the attached medical certification. This form gives your health care provider permission to release only the information in your health care records that relate to your current condition, which is the subject of the employee's request for Paid Family Leave benefits. Your health care provider may not, however, discuss your health care information with anyone.

Duration of Revocable Release: This authorization ends after **one year**, or when you revoke the release. You can cancel this release at any time. To cancel, send a letter to the health care provider listed on this form.

This form does NOT allow your health care provider to release the following types of information, unless you specifically permit such release. Put an "X" next to any information your health provider MAY release:

☐ HIV/AIDS related information ☐ Mental health information ☐ Alcohol/drug treatment ☐ Psychotherapy notes

Health Care Provider Information

Identify the health care provider who is currently providing you with treatment for a condition that is subject to the employee's request for PFL benefits.

2. **Health care provider's name**

_____

3. **Health care provider's mailing address**

_____
Mailing address

_____
City, state, zip code, country (if not U.S.A.)

4. **Health care provider's telephone number** (provide area or country code)

_____

Care Recipient Information

5. **Care recipient's mailing address**

_____
Mailing address

_____
City, state, zip code, country (if not U.S.A.)

6. **Care recipient's Social Security number (if applicable)**

☐☐☐ - ☐☐ - ☐☐☐☐

7. **Care recipient's telephone number**
(provide area or country code)

_____

READ AND SIGN BELOW. I hereby request that the health care provider listed above give a completed Form PFL-4 to the person identified above. I understand that such information includes a diagnosis and prognosis of my current condition, the date it commenced, and any estimation of the amount of care that I require from the employee requesting PFL benefits as a result of my current condition.

_____ ☐☐ / ☐☐ / ☐☐☐☐
Care recipient's signature — Date signed (MM/DD/YYYY)

Authorized representative

I, _____, represent the care recipient in this matter as authorized by:
Print name

○ Parental right ○ Power of attorney (attach copy) ○ Court order (attach copy) ○ Health care proxy (attach copy)

_____ ☐☐ / ☐☐ / ☐☐☐☐
Authorized representative's signature — Date signed (MM/DD/YYYY)

The employee should retain a copy for his or her own records.

Request For Paid Family Leave
Release Of Personal Health Information Under The Paid Family Leave Law (Form PFL-3)

If an employee is requesting PFL to care for a family member with a serious health condition, the care recipient or an authorized representative must complete a *Release Of Personal Health Information Under The Paid Family Leave Law (Form PFL-3)* and submit it to his or her health care provider, along with a copy of the *Health Care Provider Certification For Care Of Family Member With Serious Health Condition (Form PFL-4)*.

The *Release Of Personal Health Information Under The Paid Family Leave Law (Form PFL-3)* enables the health care provider to complete *Health Care Provider Certification For Care Of Family Member With Serious Health Condition (Form PFL-4)* and release it to the employee seeking PFL benefits. The employee requesting PFL then submits both the PFL-1 and the *Health Care Provider Certification For Care Of Family Member With Serious Health Condition (Form PFL-4)* to his or her employer's PFL insurance carrier, or to his or her employer if the employer is self-insured, for PFL benefit determination.

Before completing and signing, the care recipient must read the *Release Of Personal Health Information Under The Paid Family Leave Law (Form PFL-3)* in its entirety.

This form will be retained by the health care provider. The employee should make a copy for his or her records before giving it to the health care provider.

TO PERMIT THE RELEASE OF PERSONAL HEALTH INFORMATION BY THE HEALTH CARE PROVIDER FOR A FAMILY MEMBER WITH A SERIOUS HEALTH CONDITION (to be completed by care recipient)

The PFL insurance carrier name requested at the top of the form is the same as the PFL insurance carrier identified in *Request For Paid Family Leave (Form PFL -1)* Part B line 14.

Care recipient or authorized representative must complete all applicable requested information.

If a care recipient is unable to fill out this form, an authorized representative must attach a copy of legal documentation, such as a health care proxy or power of attorney, permitting the representative to sign on behalf of the care recipient. The health care provider will require this documentation of authorization unless the authorized representative is a parent signing on behalf of a minor child.

Care recipient or authorized representative signs and dates.
This form is given to the care recipient's health care provider along with the *Health Care Provider Certification For Care Of Family Member With Serious Health Condition (Form PFL-4).*

Paid Family Leave Program

Request for Paid Family Leave

Health Care Provider Certification For Care Of Family Member With Serious Health Condition (Form PFL-4)

TO BE COMPLETED BY THE EMPLOYEE

Employee's name
(first name, middle initial, last name) _____

Last 4 digits of employee's Social Security number (or TIN) ☐☐☐☐

Employee's mailing address

Mailing address

City, state, zip code, country (if not U.S.A.)

HEALTH CARE PROVIDER CERTIFICATION FOR CARE OF FAMILY MEMBER WITH SERIOUS HEALTH CONDITION

(to be completed by the health care provider and returned to the aboved named employee)

Patient Information (family member with serious health condition)

1. **Patient's name**

2. **Patient's date of birth** (MM/DD/YYYY) ☐☐ / ☐☐ / ☐☐☐☐

3. **Does patient require care by the employee requesting Paid Family Leave (PFL)?** ◯ Yes ◯ No (If no, skip to "Health Care Provider Information".)

   For the purposes of this section, "providing care" may include necessary physical care, emotional support, visitation, assistance in treatment, transportation, arranging for a change in care, assistance with essential daily living matters, and personal attendant services.

4. **Primary ICD-10 code** ☐☐☐☐☐☐☐

5. **Secondary ICD-10 code** ☐☐☐☐☐☐☐

6. **Date patient's condition commenced** (MM/DD/YYYY) ☐☐ / ☐☐ / ☐☐☐☐

7. **First date care for patient is needed** (MM/DD/YYYY) ☐☐ / ☐☐ / ☐☐☐☐

8. **Expected date patient will no longer require care** (MM/DD/YYYY) ☐☐ / ☐☐ / ☐☐☐☐

9. **Estimated number of days per week OR days per month patient requires care** _____ Days/week OR _____ Days/month

Health Care Provider Information

10. **Health care provider's name**

11. **Type of health care provider:**
    - ◯ Medical Doctor (MD)
    - ◯ Doctor of Osteopathy (DO)
    - ◯ Doctor of Podiatric Medicine (DPM)
    - ◯ Doctor of Chiropractic Medicine (DC)
    - ◯ Dentist (DDS/DDM)
    - ◯ Physician's Assistant (PA)
    - ◯ Nurse Practitioner (NP)
    - ◯ Licensed Psychologist
    - ◯ Licensed Social Worker (LMSW/LCSW)
    - ◯ Other (specify) _____

12. **Health care provider's mailing address**

    Mailing address

    City, state, zip code, country (if not U.S.A.)

13. **Health care provider's telephone number** (provide area or country code)

14. **Health care provider's fax number** (provide area or country code)

15. **Health care provider's email address** (optional)

16. **State or country (if not U.S.A.) in which health care provider is licensed to practice**

17. **Specialty**

18. **Health care provider's license number**

Certification and signature

Any person who knowingly and with intent to defraud presents, causes to be presented, or prepares with knowledge or belief that it will be presented to or by an insurer, or self-insurer, any information containing any false material statement or conceals any material fact shall be guilty of a crime and subject to substantial fines and imprisonment.

My signature attests that the information I have provided in this form is based on my professional assessment within my licensed scope of practice.

Health care provider's signature

Date signed (MM/DD/YYYY) ☐☐ / ☐☐ / ☐☐☐☐

Request For Paid Family Leave
Health Care Provider Certification For Care Of Family Member With Serious Health Condition (Form PFL-4)

The employee requesting PFL to care for a family member with a serious health condition must submit the *Health Care Provider Certification For Care Of Family Member With Serious Health Condition (Form PFL-4)* with the *Request For Paid Family Leave (Form PFL-1).*

Employee enters name, address and last four digits of his or her Social Security (or TIN) number at the top.

HEALTH CARE PROVIDER CERTIFICATION FOR CARE OF FAMILY MEMBER WITH SERIOUS HEALTH CONDITION
(to be completed by the health care provider and returned to the employee named at the top of the form)

The care recipient's health care provider must complete all applicable requested information unless noted as optional.

The care recipient's health care provider must complete the Patient Information and Health Care Provider sections of the *Health Care Provider Certification For Care Of Family Member With Serious Health Condition (Form PFL-4).*

Health Care Provider signs and dates, and then returns the form to the employee requesting PFL.

If you believe the care recipient is the victim of abuse or neglect caused by the employee requesting PFL, you may decline to provide this certification.

Paid Family Leave Program

Request for Paid Family Leave
Military Qualifying Event (Form PFL-5)

TO BE COMPLETED BY THE EMPLOYEE

Employee's name (first name, middle initial, last name) _____

Last 4 digits of employee's Social Security number (or TIN) ☐☐☐☐

MILITARY QUALIFYING EVENT (to be completed by employee)

1. **Name of military member on covered active duty or call to covered active duty status** (first name, middle initial, last name)

2. **Military member's date of birth** (MM/DD/YYYY) ☐☐ / ☐☐ / ☐☐☐☐

3. **Military member's mailing address**

Mailing address

City, state, zip code, country (if not U.S.A.)

4. **Military member's gender** ◯ Male ◯ Female

5. **The above-named military member is employee's:**
◯ Spouse ◯ Child
◯ Domestic partner ◯ Parent

6. **Period of military member's covered active duty** (MM/DD/YYYY)
☐☐ / ☐☐ / ☐☐☐☐ to ☐☐ / ☐☐ / ☐☐☐☐

7. **Please select one of the following and attach the indicated document to support that the military member is on covered active duty or impending call to covered active duty status:**
◯ Covered active duty orders
◯ Letter of impending call to covered duty
◯ Documentation of military leave signed by the approving authority for military member's Rest and Recuperation

Qualifying Reason For Leave

8. **Describe the reason employee is requesting PFL due to a qualifying event**

9. **Written documentation supporting this request for leave is available and attached?** ◯ Yes ◯ No ◯ None Available

A complete and sufficient certification to support a request for PFL leave due to a qualifying event includes any available written documentation which supports the need for leave; such documentation may include a copy of a meeting announcement for informational briefings sponsored by the military; a document confirming the military member's Rest and Recuperation leave; a document confirming an appointment with a third party, such as a counselor or school official, or staff at a care facility; or a copy of a bill for services for the handling of legal or financial affairs.

Leave For Meetings (if applicable)

If leave is requested to meet with a third party, the employee must provide supporting documentation of the meeting that includes the name, address, and appropriate contact information of the individual or entity with whom you are meeting (i.e., either the telephone number, fax number or email address of the individual or entity). The reason for a meeting can include: arranging for child or parental care, counseling, making financial or legal arrangements, acting as the military member's representative before a federal, state or local agency for purposes of obtaining, arranging or appealing military service benefits, or attending any event sponsored by the military or military service organizations.

10. **Name of individual with whom employee is meeting**

11. **Title**

12. **Organization**

13. **Telephone number** (provide area or country code)

14. **Mailing address**

Mailing address

City, state, zip code, country (if not U.S.A.)

15. **Fax number** (provide area or country code)

16. **Email address**

17. **Describe nature of meeting:**

18. **Estimate the frequency and duration of each appointment, meeting, or leave event, including any travel time (e.g., one deployment-related meeting every month):**

Declaration and signature

Any person who knowingly and with intent to defraud presents, causes to be presented, or prepares with knowledge or belief that it will be presented to or by an insurer, or self-insurer, any information containing any false material statement or conceals any material fact shall be guilty of a crime and subject to substantial fines and imprisonment.

I am hereby making a request for paid family leave benefits under the NYS Workers' Compensation Law. My signature affirms that the information I am providing is true and accurate to the best of my knowledge and belief.

Employee's signature

Date signed (MM/DD/YYYY) ☐☐ / ☐☐ / ☐☐☐☐

Request For Paid Family Leave
Military Qualifying Event (Form PFL-5)

If an employee is requesting PFL because of a family member's active military duty or impending active duty, the employee must submit the *Military Qualifying Event (Form PFL-5)* with the *Request For Paid Family Leave (Form PFL-1).*

The employee must identify the family member called to service, provide a copy of the member's active or impending duty orders, and describe the reason leave is being requested.

MILITARY QUALIFYING EVENT (to be completed by the employee)

The employee requesting PFL must complete all applicable requested information.

Employee enters name and last four digits of his or her Social Security (or TIN) number at the top.

Enter the military member's information, and indicate the military member's relationship to the employee.

Question 6: Enter dates of expected military covered active duty.

Question 7: Documentation that shows that the military member is on covered active duty or is on impending call to covered active duty is required and must be attached to this form. Select the type of documentation that is attached from the list below.

Required documentation includes one of the following:

- Covered active duty orders; OR
- Letter of impending call to covered duty; OR
- Documentation of military leave signed by the approving authority for military member's Rest and Recuperation.

Qualifying Reason for Leave

Question 8: Explain the need for PFL because of the Military Qualifying Event. For example: "My spouse was just called on short notice to covered active duty status, and will be deployed to (country) in five days. I need to take PFL to be with them and make arrangements for while they are away on active duty." If the explanation will not fit in the space provided on the form, enter "See Attached" and add an attachment with the explanation. Be sure to include the employee's full name and last four digits of his or her Social Security number (or TIN) at the top of the attachment.

Question 9: Include one or more of the qualifying supporting documents:

- Meeting announcement for informational briefing sponsored by the military; or
- Document(s) confirming an appointment with a school official, doctor, attorney or financial advisor; or
- Copy of a bill for services for the handling of legal or financial affairs.

Leave for Meetings (if applicable)

If the PFL request is to meet with a third party (such as to arrange child care or parental care, attend counseling, etc.), enter the meeting information, including the meeting's purpose, with whom it will take place, and contact information. Attach supporting documentation for each meeting.

Employee signs and dates.