



**THE CITY OF NEW YORK
DEPARTMENT OF SANITATION
GENERAL ORDER 2009 - 21**

EFFECTIVE DATE: November 24, 2009

SUBJECT: GRANTING AND APPROVING EMERGENCY LEAVE
FOR UNIFORMED AND CIVILIAN EMPLOYEES.

AFFECTED DIRECTIVES: RESCINDS OPERATIONS ORDER 2008-03
Dated; February 1, 2008.
FAMILY AND MEDICAL LEAVE ACT (FMLA)
Enacted February 5, 1993 - Amended January 28, 2008
DEPARTMENT OF PERSONNEL PPP 600-94

GRANTING EMERGENCY LEAVES:

The Department realizes that an employee may not be able to report to work or may have to leave work because of an emergency. When an employee has an emergency, the employee must notify their immediate supervisor that they have an emergency and cannot report to work. The employee will be told that he or she will be carried absent until proof of the emergency is submitted and approved by the Borough Chief/Division Head. The time book will be marked in pencil, with an -A- until the Borough Chief/Division Head determines how the employee is to be carried. Failure to provide documentation satisfactory to the Department may result in disciplinary charges preferred against the employee.

Definition: Emergency - A sudden unforeseen situation that requires
Immediate action.

District Superintendents and Unit Supervisors will record the circumstances and date the leave was granted or denied and what disciplinary action was taken, if warranted, in the location's Absence Control Log D.S. 1426.

It is the responsibility of the employee to submit proof of the emergency, **within Two Scheduled Work Days** after the employee returns to work, to the employee's District Superintendent or Unit Supervisor. If the submitted proof is deemed unsatisfactory, the employee shall have five additional scheduled work days from the time he or she is notified of such insufficiency to submit proof satisfactory to the Department. If the proof is based on a medical emergency, the documentation must be from a health practitioner, as defined in CFR Title 29, Chapter V, Subpart H, Section 825800, (5), licensed by the state in which he or she practices to diagnose and certify illness or disability.

APPROVING EMERGENCY LEAVES:

The District Superintendent or Unit Supervisor will ensure that a D.S. 1005 is completed and attached to the proof of emergency within the approved time period. The District Superintendent/Unit Supervisor will immediately submit the completed forms, through channels, with endorsements, to the Borough Chief or Division Head. Authority for determining whether or not the proof submitted is "satisfactory" will be the sole responsibility of the Borough Chief/Division Head or their respective staff designee or the Personnel Management Division. The D.S. 1005 and the submitted proof, whether granted or denied, will be kept in the employee's personnel file.

The Borough Chief or Division Head can approve, subject to acceptable documentation, a combination of up to three (3) emergency leave occurrences, including Emergency Child Care leave, in a twelve (12) consecutive month period that may be charged to available compensatory time credited to such employee. A chart change, vacation time or non-FMLA Leave Without Pay can also be granted at the Borough Chief/Division Head's discretion.

Additional requests for emergency leave made within the twelve (12) consecutive month period may be approved by the Borough Chief or Division Head as non-FMLA Leave Without Pay only. When reviewing requests for emergency leave beyond the initial three, the Borough Chief or Division Head has the discretion to consider the circumstances upon which the request is made as well as the requesting employee's overall work history and performance. Approval of Emergency Leave with pay for the fourth and all subsequent requests can only be approved by the Chief of Personnel Management Division; in the Bureau of Waste Disposal, the Deputy Director; or in other divisions, the Deputy Commissioner or Division Head.

Absent an acceptable reason, an employee may be subject to disciplinary action for failing to submit proof of the emergency by the employee's second scheduled work day after the employee returns to work; or by submitting proof that is deemed unsatisfactory. Unsatisfactory proof includes but is not limited to the employee's failure to establish that an emergency existed or the failure to submit satisfactory proof verifying the emergency. In addition, the employee will not be paid for the time off granted for the emergency and will be carried absent ("A") in the time book. This applies to all requests for emergency leave.

If the proof for the emergency leave consists of a completed and acceptable DS # 275, submitted pursuant to the FMLA, the leave will not affect the three leave approvals discretionary with the Borough Chief/Division Head.

CHILD CARE EMERGENCY:

For the purpose of this order, the definition of Child Care Emergency shall be:

A sudden, unforeseen situation resulting in the inadequate supervision of a dependant child of which an employee of the Department is a parent or legal guardian.

A child care emergency may or may not also qualify for coverage under the FMLA depending on the severity and circumstances of the illness.

Employees who are single parents or reside in a household in which both parents are gainfully employed or who are otherwise legally responsible for a dependant child or children including step children, may be excused for instances of Child Care Emergencies providing that the employee is able to substantiate that the employee has a dependant child or children with the submission of a valid birth certificate, legal document that verifies that the employee is a parent or legal guardian for the child or other documentation acceptable to the Department. For emergencies involving non-FMLA child care, employees are required to submit both the general emergency leave form (Form DS 1005) and the form for non-FMLA Child Care Leave (Form DS 274).

In instances involving **non - FMLA medical emergencies**, the employee must submit a signed statement describing the emergency, why the employee was required to respond, why the other parent or guardian was unavailable and such other supporting documentation as may be available. As the occasional unavailability of a care giver is reasonably anticipated, such **repeated** unavailability of the child's care giver is not acceptable as a justification for granting a request for emergency leave.

Child care leave requests that are undocumented, unsatisfactory or fraudulent, will result in a DS 249 Complaint issued to the employee. The first five complaints (DS 249) issued, within a twelve month period, for undocumented or unsatisfactory documentation, may, at the discretion of the Department, be heard at a BCAD hearing. Subsequent Complaints will be referred to the Department Advocate for adjudication.

The Family and Medical Leave Act (FMLA) provides for leave chargeable to leave balances or without pay for, among other reasons, children's serious health conditions and the treatment of those conditions. (New York City PPP 600-94 requires the use of paid leave before unpaid leave.) A serious health condition as set forth in CFR, Title 29, Chapter V, Part 825, Section 825.800, does not include the common cold, upset stomach, head ache, and routine dental problems unless complications develop. Such leave is subject to proof of responsibility for the child, such as a birth certificate and medical documentation through completion of the United States Department of Labor Form WH-380-F, which is available to employees as DS 275. When prescribed, leave pursuant to the FMLA may be for a course of treatment requiring periodic treatment or for chronic conditions that recur from time to time.

GENERAL ORDER 2009-21

Notwithstanding any other order to the contrary, when the leave request is pursuant to the FMLA, the medical documentation required by this Order must be provided on United States Department of Labor Form WH-380-F, revised January 2009. (Attached hereto as **DS # 275**) Timely submission of form **DS #275** (WH-380-F) shall be in accordance with Section II of the Form.

The provisions of this order pertain only to emergency situations and it does not in any way change the established procedures for requesting vacation changes or leave for special situations, as outlined in Operations Order 99 -10 dated December 1, 1999, or such other orders, rules or regulations as may apply.

Borough Chiefs/Division Heads or their staff designee will monitor all the D.S. 1426 - Absence Control Logs in their command for completeness and accuracy.

CANCELLATION: This order shall remain in effect until rescinded

ISSUING AUTHORITY:


John J. Doherty
Commissioner

DISTRIBUTION: All Management Personnel, Unit Supervisors, All Locations.

DS 274

REQUEST FOR NON-FMLA CHILD CARE LEAVE

Name: _____
(Print)

Title: _____
(Print)

Work Location: _____
(Print)

My request for non-FMLA child care leave is based on the following facts:

Required Documentation:

Proof of child/children's dependency -- attached [] _____

Basis for request (Check any box that applies and provide explanation below.)

Spouse/guardian's employment. - [] _____

Hours of spouse/guardian's employment on date of leave request -- [] _____

Name and address where spouse/guardian is employed -- [] _____

Alternative care-giver on date of leave request. - [] _____

Other Reason. - [] _____

Explanation as required by Operations Order 2009-21- [] _____

I hereby certify that the foregoing is complete, true and accurate.

Signature: _____

Date: _____

(Attach any required documentation)

SECTION III: For Completion by the HEALTH CARE PROVIDER

INSTRUCTIONS to the HEALTH CARE PROVIDER: The employee listed above has requested leave under the FMLA to care for your patient. Answer, fully and completely, all applicable parts below. Several questions seek a response as to the frequency or duration of a condition, treatment, etc. Your answer should be your best estimate based upon your medical knowledge, experience, and examination of the patient. Be as specific as you can; terms such as "lifetime," "unknown," or "indeterminate" may not be sufficient to determine FMLA coverage. Limit your responses to the condition for which the patient needs leave. Page 3 provides space for additional information, should you need it. Please be sure to sign the form on the last page.

Provider's name and business address: _____

Type of practice / Medical specialty: _____

Telephone: (_____) _____ Fax: (_____) _____

PART A: MEDICAL FACTS

1. Approximate date condition commenced: _____

Probable duration of condition: _____

Was the patient admitted for an overnight stay in a hospital, hospice, or residential medical care facility?

No Yes. If so, dates of admission: _____

Date(s) you treated the patient for condition: _____

Was medication, other than over-the-counter medication, prescribed? No Yes.

Will the patient need to have treatment visits at least twice per year due to the condition? No Yes

Was the patient referred to other health care provider(s) for evaluation or treatment (e.g., physical therapist)?

No Yes. If so, state the nature of such treatments and expected duration of treatment:

2. Is the medical condition pregnancy? No Yes. If so, expected delivery date: _____

3. Describe other relevant medical facts, if any, related to the condition for which the patient needs care (such medical facts may include symptoms, diagnosis, or any regimen of continuing treatment such as the use of specialized equipment):

PART B: AMOUNT OF CARE NEEDED: When answering these questions, keep in mind that your patient's need for care by the employee seeking leave may include assistance with basic medical, hygienic, nutritional, safety or transportation needs, or the provision of physical or psychological care:

4. Will the patient be incapacitated for a single continuous period of time, including any time for treatment and recovery? ___ No ___ Yes.

Estimate the beginning and ending dates for the period of incapacity: _____

During this time, will the patient need care? ___ No ___ Yes.

Explain the care needed by the patient and why such care is medically necessary:

5. Will the patient require follow-up treatments, including any time for recovery? ___ No ___ Yes.

Estimate treatment schedule, if any, including the dates of any scheduled appointments and the time required for each appointment, including any recovery period:

Explain the care needed by the patient, and why such care is medically necessary: _____

6. Will the patient require care on an intermittent or reduced schedule basis, including any time for recovery? ___ No ___ Yes.

Estimate the hours the patient needs care on an intermittent basis, if any:

_____ hour(s) per day; _____ days per week from _____ through _____

Explain the care needed by the patient, and why such care is medically necessary:

7. Will the condition cause episodic flare-ups periodically preventing the patient from participating in normal daily activities? ___ No ___ Yes.

Based upon the patient's medical history and your knowledge of the medical condition, estimate the frequency of flare-ups and the duration of related incapacity that the patient may have over the next 6 months (e.g., 1 episode every 3 months lasting 1-2 days):

Frequency: ___ times per ___ week(s) ___ month(s)

Duration: ___ hours or ___ day(s) per episode

Does the patient need care during these flare-ups? ___ No ___ Yes.

Explain the care needed by the patient, and why such care is medically necessary: _____

ADDITIONAL INFORMATION: IDENTIFY QUESTION NUMBER WITH YOUR ADDITIONAL ANSWER.

Signature of Health Care Provider

Date

PAPERWORK REDUCTION ACT NOTICE AND PUBLIC BURDEN STATEMENT

If submitted, it is mandatory for employers to retain a copy of this disclosure in their records for three years. 29 U.S.C. § 2616; 29 C.F.R. § 825.500. Persons are not required to respond to this collection of information unless it displays a currently valid OMB control number. The Department of Labor estimates that it will take an average of 20 minutes for respondents to complete this collection of information, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. If you have any comments regarding this burden estimate or any other aspect of this collection information, including suggestions for reducing this burden, send them to the Administrator, Wage and Hour Division, U.S. Department of Labor, Room S-3502, 200 Constitution Ave., NW, Washington, DC 20210. **DO NOT SEND COMPLETED FORM TO THE DEPARTMENT OF LABOR; RETURN TO THE PATIENT.**

DS 274

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(Print)

Title: _____
(Print)

Work Location: _____
(Print)

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Name and address where spouse/guardian is employed - [] _____

Alternative care-giver on date of leave request. - [] _____

Other Reason. - [] _____

Explanation as required by Operations Order 2009-21- [] _____

I hereby certify that the foregoing is complete, true and accurate.

Signature: _____

Date: _____

(Attach any required documentation)