Unlimited Paid Sick Leave for Employees with a Qualifying World Trade Center Condition Reference Guide

Purpose/Objective:
Pursuant to legislation enacted by the State of New York, CUNY will provide unlimited paid sick leave for incapacity from or treatment for a "Qualifying World Trade Center Condition" to employees who participated in the World Trade Center rescue, recovery, and cleanup operations.

Eligibility:
Employees can apply for this leave as of their date of hire.

To be eligible, active full-time and part-time employees must have:

1. Participated in World Trade Center ("WTC") rescue, recovery, and cleanup operations as verified by an approved "Notice of Participation" from a public retirement system, including but not limited to New York State and Local Retirement System, New York City ("NYC") Employee's Retirement System, NYC Fire Pension Fund, NYC Police Pension Fund, or NYC Teacher's Retirement System.

2. A "Qualifying World Trade Center Condition" as defined in Section 2 of the NYS Retirement System and Social Security Law or a "9/11 Related Illness" covered under the federal WTC Health Program as diagnosed by a qualified medical professional.

Benefit:
On a prospective basis, eligible employees shall not have to charge sick leave, but will instead receive unlimited leave with pay, without charge to leave credits for any absences related to their qualifying condition. This leave may be taken for either full or partial day absences. Employees must follow their current college's procedures for requesting leave and provide appropriate medical documentation that the absence was due to incapacity, medical treatment, or medical testing related to the employee's qualifying WTC condition (see further below.)

For prior absences related to an employee's qualifying WTC condition, the employee may seek restoration of previously used sick leave. The employee may apply for that restoration retroactively to the date the employee was diagnosed with a qualifying WTC condition.

Required Documentation and Application Procedures:
Employees seeking to use unlimited paid sick leave for a qualifying WTC condition must submit:

1. A written request for such leave along with "Notice of Participation" in WTC rescue, recovery, or cleanup operations and an acceptance letter from a public retirement system.

2. Medical documentation of their Qualifying WTC Condition or 9/11 Related Illness and the date the condition commenced.

Employees seeking to use unlimited paid sick leave for a qualifying WTC condition may be required to submit:

1. Additional medical documentation certifying that a specific absence was due to a Qualifying WTC Condition or 9/11 Related Illness.
2. A written waiver of their rights under the Health Insurance Portability and Accountability Act ("HIPAA") to allow for disclosure of notice of participation and medical records concerning their Qualifying WTC Condition or 9/11 Related Illness.

Miscellaneous:

1. Leave provided pursuant to the Family and Medical Leave Act ("FMLA") shall run concurrently with paid sick leave for a qualifying WTC condition.
2. Employees using paid sick leave for a qualifying WTC condition will continue to accrue annual and sick leave in accordance with their current leave accrual schedule.

AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION PURSUANT TO HIPPA

Patient Name	Date of Birth	Social Security Number (Last 4 digits only)
Patient Address		

I, or my authorized representative, request that health information regarding my care and treatment be released as set forth on this form:

In accordance with New York State Law and the Privacy Rule of the Health Insurance Portability and Accountability Act of 1996 (HIPPA), I understand that:

1. This authorization may include disclosure of information relating to my participation in the World Trade Center (WTC) rescue, recovery and cleanup operations and 9/11 Related Illness.
2. This authorization may include disclosure of information relating to **ALCOHOL, DRUG ABUSE and MENTAL HEALTH TREATMENT**, except psychotherapy notes, only if I place my initials on the appropriate line in Item 8(a). In the event the health information described below includes any of these types of information, and I initial the line on the box in Item 8(a), I specifically authorize release of such information to the person(s) indicated in Item 7.
3. If I am authorizing the release of, alcohol or drug treatment, and/or mental health treatment information, the recipient is prohibited from re-disclosing such information without my authorization unless permitted to do so under federal or state laws. I understand that I have the right to request a list of people who may receive or use my mental health information without authorization. If I experience discrimination because of the release or disclosure of mental health-related information, I may contact the New York State Division of Human right at (212) 480-2493 or the New York City Commission of Human Rights at (212) 306-7450. These agencies are responsible for protecting my rights.
4. I have the right to revoke this authorization at any time by writing to the health care provider listed below. I understand that I may revoke this authorization except to the extent that action has already been taken based on this authorization.
5. I understand that signing this authorization is voluntary. My treatment, payment, enrollment in a health plan, or eligibility for benefits will not be conditioned upon my authorization of this disclosure
6. **THIS AUTHORIZATION DOES NOT AUTHORIZE YOU TO DISCUSS MY HEALTH INFORMATION OR MEDICAL CARE WITH ANYONE OTHER THAN THE OFFICE OF HUMAN RESOURCES AT THE CITY UNIVERSITY OF NEW YORK.**

7. Name and address of health provider or entity to release this information:

8. Name and address of person(s) or category of person to whom this information will be sent:

8(a). Specific information to be released:

□ Medical Record from (insert date)_____to (insert date)_____

□ Entire Medical record, including patient histories, office notes (except psychotherapy notes), test results, radiology studies, films, referrals, consults, billing records, insurance records, and records sent to you by other health care providers.

□ Other: _____ Include: (indicate by initialing)

_____ _____**Alcohol/Drug Treatment**

_____ _____**Mental Health Information**

Authorization to Discuss Health Information:

(b) By initialing here _____I authorize _____

initials Name of individual health care provider

to discuss my health information with The Office of Human Resources at The City University of New York.

10. Reason for release of information: □ At request of individual □ Other:	11. Date or event on which this authorization will expire:
12. If not the patient, name of person signing form:	13. Authority to sign on behalf of patient:

All items on this form have been completed and my questions about this form have been answered. In addition, I have been provided a copy of this form.

_____ Date:_____

Signature of patient or representative authorized by law