FORMAL REQUEST FOR REINSTATEMENT REGARDING PAID FAMILY LEAVE

Paid Family Leave ● PO Box 9030, Endicott, NY 13761-9030

You are entitled to return to the same or comparable position when you return to work after taking Paid Family Leave.

Employee Instructions

Use this form if, after you request or take Paid Family Leave, your employer:

- Refuses to reinstate you to your original or comparable position,
- Terminates your employment,
- Reduces your pay and/or benefits, and/or
- Disciplines you in any way.

If you believe any of these have happened, you **must first** formally request reinstatement using this form.

1. Fill out Sections A, B, and C of this form.
2. Make a copy of all pages and deliver the copy to your employer.
3. Once you have delivered the copy, immediately fill out Section D of this form. DO NOT wait for your employer to complete Section E.
4. Make a copy of all pages to save for your records.
5. Send a copy of the form (with Sections A, B, C, and D completed) to the **Workers' Compensation Board: Paid Family Leave at PO Box 9030, Endicott, NY 13761-9030** or email to PaidFamilyLeave@wcb.ny.gov.

What Happens Next?

Your employer has 30 days from the filing date* of this request to:

1. Take corrective action, which may include reinstating you to the same or a comparable position; or
2. Complete Section E of this form, explaining to you why they believe no corrective action is required.

If you are reinstated by your employer, no further action is necessary.

If you are NOT reinstated, you are not satisfied with your employer's response, or your employer does not respond to this request within 30 days:

- You can then file a *Paid Family Leave Discrimination/Retaliation Complaint (PFL-DC-120)* available at www.ny.gov/PaidFamilyLeave.
- You and your employer will be required to appear at a hearing before a Workers' Compensation Law Judge who will decide if the law was violated. If it was, your employer may be ordered to reinstate you, pay back wages, and/or attorney fees.

* The 30 days begins the day that you certified delivery of this form to your employer noted in the "Certification of Delivery" on page 2.

Employer Instructions

Employers, this a Formal Request for Reinstatement from an employee who believes they have been discriminated or retaliated against for requesting or taking Paid Family Leave.

Please see page 3 for your instructions.

DO NOT SCAN THIS PAGE

NEW YORK STATE | Paid Family Leave

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Section A - To be completed by the employee

Employee's Information

Name (LAST, FIRST, MI): _____ Date of Birth: _____

Street Address: _____

City, State, Zip Code: _____

Phone #: _____ Social Security # / Tax Identification #: _____

Email Address: _____

Employee's Gender: ☐ M ☐ F ☐ X

Employer's Information (AS IT APPEARS ON YOUR PAY STUB)

Employer's Name: _____

Employer's Street Address: _____

Employer's City, State, Zip Code: _____

Employer's Phone #: _____ Federal Identification #, if known (FEIN): _____

Paid Family Leave Information

Check ONE of the following:

☐ Paid Family Leave was formally requested and granted Start Date: _____ End Date: _____

☐ Paid Family Leave was formally requested and denied

☐ Other (PLEASE EXPLAIN): _____

Date request (PFL-1) or mention of Paid Family Leave was made to employer (if applicable): _____

Type of Paid Family Leave: ☐ Bonding with a Child ☐ Care for Family Member ☐ Qualifying Military Event

Attorney Information (PLEASE COMPLETE THE FOLLOWING IF YOU HAVE OBTAINED AN ATTORNEY IN THIS MATTER)

Attorney's Name: _____

Attorney's Street Address: _____

Attorney's City, State, Zip Code: _____

Attorney's Phone #: _____ Board ID # (IF ANY): R- _____

Section B - To be completed by the employee

Employee's Request for Reinstatement - Using the check-boxes below, indicate the corrective action you believe your employer must take (CHECK ALL THAT APPLY).

I requested or took Paid Family Leave and:

☐ My employment was terminated and I want my job back.

☐ My hours were reduced or changed. I want to return to working the same schedule as before I requested or took Paid Family Leave.

☐ My job duties changed. I want to return to the same or a comparable job as before I requested or took Paid Family Leave.

☐ My benefits were canceled or reduced. I want my benefits returned to the same level as before I requested or took Paid Family Leave. (Benefits may include, for example, health insurance).

☐ Other/Additional Information (PLEASE EXPLAIN):

_____

_____

_____

If you need assistance, please call (844) 337-6303
www.ny.gov/PaidFamilyLeave

Employee Name (LAST, FIRST, MI): _____ Social Security # / TIN #: _____

Section C - To be completed by the employee

I AFFIRM UNDER THE PENALTY OF PERJURY THAT THE INFORMATION PROVIDED HEREIN IS TRUE TO THE BEST OF MY KNOWLEDGE:

_____ _____

Employee's Signature Date

Note to Employee: After delivery of a copy of this form (with Sections A-C completed) to your employer, complete Section D and send all pages to the **Workers' Compensation Board: Paid Family Leave, PO Box 9030, Endicott, NY 13761-9030** or email to **PaidFamilyLeave@wcb.ny.gov** and retain a copy for your records.

Section D - To be completed by the employee

Certification of Delivery

I hereby certify, under penalty of perjury, that I delivered a copy of this Formal Request for Reinstatement Regarding Paid Family Leave to the employer listed in Section A on _____ (Date) by (CHECK ONE OF THE FOLLOWING):

☐ Mailed it to the employer's address listed on this form

☐ Personally delivered to:

Name: _____

Street Address: _____

City, State, Zip Code: _____

☐ Emailed attachment to:

Name: _____

Email Address: _____

☐ Faxed to _____

Employee's Signature _____ Date _____

If you need assistance, please call (844) 337-6303
www.ny.gov/PaidFamilyLeave

Employee Name (LAST, FIRST, MI): _____ Social Security # / TIN #: _____

Employer Instructions

Under Workers' Compensation Law sections 203-b and 120, if any employee requests to take Paid Family Leave:

- You must reinstate them to their original or comparable position,
- You may NOT terminate them,
- You may NOT reduce their pay and/or benefits,
- You may NOT discipline them for requesting or taking Paid Family Leave.

Within **30 days** from the filing date* of this request, you are required to:

1. Take corrective action, which may include reinstating the employee to the same or a comparable position; or
2. Complete Section E of this form, explaining to the employee why corrective action will not be permitted. A separate response may be sent, but must be attached to this form. **Pages 1-3 of this form and any attachments must be sent to the employee, the employee's attorney (if one is listed on this form) and to the Workers' Compensation Board: Paid Family Leave at PO Box 9030, Endicott, NY 13761-9030** or email to PaidFamilyLeave@wcb.ny.gov.

Failure to reinstate an employee can result in damages being imposed against you that are not covered by insurance.

If the employee is reinstated or does not want to pursue a discrimination/retaliation complaint after they receive your response to this request, no further action is required. Otherwise, after 30 days, the employee has the right to file a complaint with the Workers' Compensation Board. If the Board finds you violated section(s) 203-b and/or 120 of the Workers' Compensation Law, it may order you to restore the employee to comparable employment, award lost wages starting from the end of leave with interest, award attorney(s) fees, and/or assess a penalty of up to $500 against you.

* The 30 days begins the day that the employee certified delivery of this form to the employer noted in the "Certification of Delivery" section on page 2.

Note to Employer: Send pages 1-3 of this form (with Section E completed) to the Workers' Compensation Board: Paid Family Leave at PO Box 9030, Endicott, NY 13761-9030 or email to PaidFamilyLeave@wcb.ny.gov when submitting your response.

Section E - To be completed by the employer

Employer's Response to Employee's Reinstatement Request

Name: _____

Street Address: _____

City, State, Zip Code: _____

Phone #: _____ Federal Identification # (FEIN): _____

Indicate your defenses by checking the applicable reason(s). You may also attach additional documentation to this form in support of your defenses.

- ☐ The shift the employee held prior to requesting or taking Paid Family Leave was eliminated.
- ☐ The overtime hours the employee worked prior to requesting or taking Paid Family leave are no longer available.
- ☐ The employee never requested or took Paid Family Leave.
- ☐ The employee/claimant was not employed by this business.
- ☐ Other/Additional Information (PLEASE EXPLAIN):

_____

_____

_____

Employer's Signature _____ Date _____

Print Name _____

If you need assistance, please call (844) 337-6303
www.ny.gov/PaidFamilyLeave