SCHENECTADY CITY COUNCIL
COMMITTEE AGENDA

for
Monday, July 1, 2019
5:30 p.m.
Room 110

The Council President reserves the right to add or delete any agenda item prior to Committee Meeting.

Public Service & Utilities
1 OSM – Rewiring Estimate                         Ed Kosiur
2 Award the Bid and Contract for the Repairs to College Creek Lenox Road Culvert Chris Wallin

Health & Recreation
1 Discussion – Clean-up Efforts for Bellevue Little League Fields & Other Parks Paul Lafond
2 Review – CR Rose Garden                          John Polimeni

Administrative Efficiency
1 Paid Family Leave (PFL)                           Ed Kosiur

Government Operations
1 CR – Honoring Joan Spelter on her 90th Birthday Leesa Perazzo
2 Discussion – Liquor Store at 844 Albany Street Ed Kosiur

City Development & Planning
1 Mohawk Harbor Large Vessel Dockage CFA           Kristin Diotte
2 Sidewalk Petition Review                         Carl Falotico
3 Sale of 38 Willow Avenue                          Andrew Koldin
4 Sale of 42 Cheltingham Street                    Andrew Koldin
5 Sale of 354 Olean Street                         Andrew Koldin
6 Sale of 454 Hegeman Street                       Andrew Koldin
7 Sale of 704 Craig Street                         Andrew Koldin
8 Sale of 802 Bridge Street                        Andrew Koldin
9 Sale of 1018 Willett Street                      Andrew Koldin
10 Sale of 1307 Union Street                       Andrew Koldin

Claims
1 Kearse v. City of Schenectady Claim Update       Carl Falotico

Public Safety
1 Discussion – Safety Features and Security in City hall John Polimeni
Committee: Public Service & Utilities

From: Ed Kosiur

Subject: OSM - Rewiring Estimate

Background Info:

Evaluation/Analysis

Recommendation
COMMITTEE ASSIGNMENT:                          DATE: July 1, 2019

TO:         City Council

FROM:  Christopher R. Wallin, P.E., City Engineer

SUBJECT:  Award the Bid and Contract for the “Repairs to College Creek Lenox Road Culvert” to Town & Country Bridge and Rail, Inc. in the amount of $109,524

TO BE PLACED ON COUNCIL AGENDA OF: July 8, 2019

Background Information:

During a routine inspection the laid up stone culvert carrying College Creek beneath Lenox Road was found to be in a state of disrepair. The damage appears to have been caused by the erosion of the culverts foundation and base stone layers.

Evaluation/Analysis:

The Engineering Department solicited and received bids for “Repairs to College Creek Lenox Road Culvert”. Low base bid was received on June 26, 2019 from Town and Country Bridge and Rail, Inc., of Albany, NY in the Amount of $109,524. Financing for this project will be from select codes.

Recommendation:

Authorize the Mayor to enter into a contract with Town & Country Bridge and Rail, Inc., for the "Repairs to College Creek Lenox Road Culvert" in the amount of $109,524.

LEGISLATION WILL BE PREPARED BY: Engineering
CRW: cd
<table>
<thead>
<tr>
<th>PAY ITEM No.</th>
<th>PAY ITEM DESCRIPTION</th>
<th>QUANTITY</th>
<th>UNIT</th>
<th>Unit Price</th>
<th>BIDDER No. 1 EXTENSION</th>
<th>Unit Price</th>
<th>BIDDER No. 2 EXTENSION</th>
<th>Unit Price</th>
<th>BIDDER No. EXTENSION</th>
</tr>
</thead>
<tbody>
<tr>
<td>203.02</td>
<td>Unclassified Excavation and Disposal</td>
<td>12</td>
<td>CY</td>
<td>$640.00</td>
<td>$7,680.00</td>
<td>$850.00</td>
<td>$10,200.00</td>
<td></td>
<td></td>
</tr>
<tr>
<td>555.07</td>
<td>Concrete for Structures, Class GG (deposited)</td>
<td>12</td>
<td>CY</td>
<td>$2,300.00</td>
<td>$27,600.00</td>
<td>$1,800.00</td>
<td>$21,600.00</td>
<td></td>
<td></td>
</tr>
<tr>
<td>556.0202</td>
<td>Epoxy-Coated Bar Reinforcement for Structures</td>
<td>1700</td>
<td>LB</td>
<td>$1.27</td>
<td>$2,159.00</td>
<td>$3.25</td>
<td>$9,525.00</td>
<td></td>
<td></td>
</tr>
<tr>
<td>560.09</td>
<td>Tuck Pointing</td>
<td>300</td>
<td>SF</td>
<td>$73.00</td>
<td>$21,900.00</td>
<td>$40.00</td>
<td>$12,000.00</td>
<td></td>
<td></td>
</tr>
<tr>
<td>560.4000008</td>
<td>Repair Stone Masonry</td>
<td>200</td>
<td>SF</td>
<td>$215.00</td>
<td>$43,000.00</td>
<td>$345.00</td>
<td>$69,000.00</td>
<td></td>
<td></td>
</tr>
<tr>
<td>697.03</td>
<td>Field Change Payment (Cannot Exceed 5% of Bid)</td>
<td>1</td>
<td>LS</td>
<td>$4,000.00</td>
<td>$4,000.00</td>
<td>0</td>
<td>0</td>
<td></td>
<td></td>
</tr>
<tr>
<td>699.040001</td>
<td>Mobilization</td>
<td>1</td>
<td>LS</td>
<td>$3,185.00</td>
<td>$3,185.00</td>
<td>$14,425.00</td>
<td>$14,425.00</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Total Base Bid:** $109,524.00 $132,750.00

<table>
<thead>
<tr>
<th>BIDDER No.</th>
<th>COMPANY NAME</th>
<th>ADDRESS</th>
<th>C.A.P</th>
<th>SECURITY DEPOSIT</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Town and Country Bridge and Rail, Inc.</td>
<td>PO Box 16395, Albany, NY 12212</td>
<td>N/A</td>
<td>Bid Bond</td>
</tr>
<tr>
<td>2</td>
<td>Carvery Construction, Inc.</td>
<td>494 Western Avenue, Altamont, NY 12009</td>
<td>N/A</td>
<td>Bid Bond</td>
</tr>
</tbody>
</table>
# Plan Holders List

<table>
<thead>
<tr>
<th>Organization Name</th>
<th>Main Contact</th>
<th>Download Date</th>
<th>City</th>
<th>Province/State</th>
</tr>
</thead>
<tbody>
<tr>
<td>Parrott Enterprises Inc.</td>
<td>Mark Ferguson</td>
<td>06/26/2019 05:57 AM EDT</td>
<td>newburgh</td>
<td>New York</td>
</tr>
<tr>
<td>Town &amp; County Bridge and Rail Inc.</td>
<td>Christopher Hart</td>
<td>06/25/2019 12:02 PM EDT</td>
<td>Albany</td>
<td>New York</td>
</tr>
<tr>
<td>A. Colarusso &amp; Son, Inc.</td>
<td>David LaSpada</td>
<td>06/25/2019 10:54 AM EDT</td>
<td>Hudson</td>
<td>New York</td>
</tr>
<tr>
<td>GPI/Greenman-Pedersen, Inc.</td>
<td>Heather Pace</td>
<td>06/24/2019 09:22 AM EDT</td>
<td>Albany</td>
<td>New York</td>
</tr>
<tr>
<td>Harrison &amp; Burrowes Bridge Constructors, Inc.</td>
<td>Joanna Sanzo</td>
<td>06/21/2019 07:02 AM EDT</td>
<td>Glenmont</td>
<td>New York</td>
</tr>
<tr>
<td>Proshot Concrete, Inc.</td>
<td>Anthony McDougle</td>
<td>06/20/2019 03:36 PM EDT</td>
<td>Florence</td>
<td>Alabama</td>
</tr>
<tr>
<td>Burt Crane &amp; Rigging</td>
<td>Bridget Hubal</td>
<td>06/20/2019 02:46 PM EDT</td>
<td>Green Island</td>
<td>New York</td>
</tr>
<tr>
<td>Carver Construction, Inc.</td>
<td>Walter Harbacz</td>
<td>06/20/2019 06:36 AM EDT</td>
<td>Altamont</td>
<td>New York</td>
</tr>
<tr>
<td>Paul S. Davis</td>
<td>gfgg yrttyy</td>
<td>06/20/2019 01:22 AM EDT</td>
<td>Memphis</td>
<td>Tennessee</td>
</tr>
<tr>
<td>IDMC</td>
<td>Bill Philips</td>
<td>06/19/2019 10:19 PM EDT</td>
<td>Grand Junction</td>
<td>Colorado</td>
</tr>
<tr>
<td>MCJ Construction</td>
<td>Jeff Sargalis</td>
<td>06/19/2019 09:53 PM EDT</td>
<td>Mayfield</td>
<td>New York</td>
</tr>
<tr>
<td>BrainSurface LLC</td>
<td>Omar Farooq</td>
<td>06/19/2019 03:53 PM EDT</td>
<td>Dallas</td>
<td>Texas</td>
</tr>
<tr>
<td>Rifenburg Contracting Corporation</td>
<td>Brian Barton</td>
<td>06/19/2019 03:37 PM EDT</td>
<td>Troy</td>
<td>New York</td>
</tr>
<tr>
<td>Superior Gunite</td>
<td>Armando Ramos</td>
<td>06/19/2019 02:50 PM EDT</td>
<td>Lakeview Terrace</td>
<td>California</td>
</tr>
<tr>
<td>New Castle Paving</td>
<td>Adrianne McMullen</td>
<td>06/19/2019 02:10 PM EDT</td>
<td>Troy</td>
<td>New York</td>
</tr>
<tr>
<td>D. A. Collins Construction Co., Inc.</td>
<td>Melissa Harvish</td>
<td>06/19/2019 11:29 AM EDT</td>
<td>Wilton</td>
<td>New York</td>
</tr>
<tr>
<td>James H. Maloy , Inc</td>
<td>Peter Maloy</td>
<td>06/19/2019 10:57 AM EDT</td>
<td>Loudonville</td>
<td>New York</td>
</tr>
<tr>
<td>Ferguson Waterworks</td>
<td>Melissa Visconte</td>
<td>06/19/2019 10:00 AM EDT</td>
<td>Clifton Park</td>
<td>New York</td>
</tr>
<tr>
<td>COMET FLASHER INC</td>
<td>JAMES WRIGHT</td>
<td>06/19/2019 09:46 AM EDT</td>
<td>BUFFALO</td>
<td>New York</td>
</tr>
<tr>
<td>Core &amp; Main LP</td>
<td>Steven Law</td>
<td>06/19/2019 09:32 AM EDT</td>
<td>Watervliet</td>
<td>New York</td>
</tr>
<tr>
<td>Prime Highway Contractors, LLC</td>
<td>Linda J Isabelle</td>
<td>06/19/2019 09:28 AM EDT</td>
<td>Albany</td>
<td>New York</td>
</tr>
</tbody>
</table>
CITY OF SCHENECTADY, NEW YORK – DEPARTMENT OF ENGINEERING
BIDDERS LIST

PROJECT TITLE: Repairs to College Creek Lenox Road Culvert

BID DUE DATE: 6/26/19 @ 10:30 A.M. E.D.S.T.  FEE FOR SPECIFICATIONS: N/A

CONTRACTOR: Town & County Bridge & Rail
STREET & NUMBER: P.O. Box 112395
CITY, STATE & ZIP: Albany, NY 12222
TELEPHONE NO.: 518-522-5673
FAX NO.: 518-581-9739
CONTACT PERSON: Frank Gavin
EMAIL ADDRESS: highwayboss@hotmail.com
MAILED/PICKED UP: picked up

CONTRACTOR: Steven J. Maggio
Maggio and Sons Land Development Co.
374 Floyd Howver Rd.
Round Top, NY 12473
ph: 518 622-9882
fax: 518 622-9553
cell: 518 965-1844
e-mail: steve@maggiosandsons.com

CONTRACTOR:
STREET & NUMBER:
CITY, STATE & ZIP:
TELEPHONE NO.: 
FAX NO.:
CONTACT PERSON:
EMAIL ADDRESS:
MAILED/PICKED UP:
Committee: Health & Recreation  
Committee Date: Monday, July 01, 2019

From: Paul Lafond

Subject  Discussion - Clean-up Efforts for Bellevue Little League Field & Other Park Fields

Background Info:

Evaluation/Analysis

Recommendation
Committee: Health & Recreation

From: John Polimeni

Subject Review - CR Rose Garden

Background Info:

Evaluation/Analysis

Recommendation
Central Park Rose Garden, sited at the Wright Avenue entrance to Schenectady’s Central Park in 1959, is celebrating its 60th anniversary in 2019. Charles D. Brown, a Schenectady resident and member of the Schenectady Rose Society, was its designer.

In April of 1960, 400 rose bushes were planted. Subsequent years saw the addition of the rockery pool, triangular fountain and reflection pool.

The garden peaked in the 1970s with an estimated rose population of 7,500 bushes.

Since 1995 a grand staircase, gate house, paver walkways, center fountain and pergola have been added to the garden.
Committee: Administrative Efficiency  Committee Date: Monday, July 01, 2019

From: Ed Kosiur

Subject: Family Paid Leave (PFL)

Background Info:

Evaluation/Analysis

Recommendation
CITY COUNCIL
SCHENECTADY, NEW YORK

RESOLUTION NO.

Councilmember offered the following:

A Resolution Amending the Benefits Package for Managerial Employees of the City of Schenectady to Include New York State Paid Family Leave.

WHEREAS, employees of the City of Schenectady who are not represented by a union have the terms and conditions of their employment set by the City Council; and

WHEREAS, the City Council has determined to opt into New York State Paid Family Leave; and

WHEREAS, Paid Family Leave is an important benefit which provides eligible employees job-protected, paid time off to bond with a newly born, adopted or fostered child, care for a family member with a serious health condition, or assist loved ones when a spouse, domestic partner, child or parent is deployed abroad on active military service; and

WHEREAS, there is no direct cost to the City of Schenectady to offer this benefit to employees:

NOW, THEREFORE BE IT,

RESOLVED, that the City Council amends the benefits package provided to employees who are not represented by a union to include New York State Paid Family Leave as soon as it is reasonable possible to do so; and be it further

RESOLVED, that the Mayor is authorized and directed to enter into any agreements necessary to opt into New York State Paid Family Leave.

Approved as to form this 8th day of July, 2019.

_________________________
Carl Falotico, Esq.
Corporation Counsel
Overview

As a Public employer, you may voluntarily opt into New York Paid Family Leave at any time.

A public employer is defined as the State, any political subdivision of the State, a public authority or any government agency or instrumentality.

Paid Family Leave coverage for non-represented employees can be determined by the Public Employer. A labor union may collectively bargain with a public employer to provide Paid Family Leave benefits to represented employees.

How PFL is Funded

New York Paid Family Leave is insurance that may be funded by employees through payroll deductions. Each year, the Department of Financial Services sets the employee contribution rate to match the cost of coverage.

In 2019, the employee contribution is 0.153% of an employee’s gross wages each pay period. The maximum annual contribution is $107.97. Pursuant to the Department of Tax Notice No. N-17-12 [PDF], Paid Family Leave contributions are deducted from employees’ after-tax wages.

Employee salary is $52K, weekly deduction for 2019 - $1.53. Rate for 2020 is set by NYS in September, 2019.

Rate calculator website - https://paidfamilyleave.ny.gov/paid-family-leave-calculator2019

Employees earning less than the Statewide Average Weekly Wage (SAWW) of $1,357.11 will contribute less than the annual cap of $107.97, consistent with their actual wages. Commissions are considered wages for PFL purposes.

Opting In – Step by Step

1. Decision by the public employer’s governing body (the form of which should be as you determine it is necessary based on your guiding statute and regulations.)

2. Obtain coverage.

3. File opt-in notice (Employer’s Application for Voluntary Coverage) with the Workers’ Compensation Board.

4. Provide 90-days’ notice to non-represented employees.

5. Identify employees who qualify for a waiver.

6. Collect payroll deductions to pay for the PFL insurance premium.
Notify the Workers’ Compensation Board

Public employers must notify the Workers’ Compensation Board when they opt into Paid Family Leave.

To notify the Workers’ Compensation Board, complete the Employer’s Application for Voluntary Coverage.

Completed applications should be submitted to the Plans Acceptance Unit via email at PAU@wcb.ny.gov.

Depending on whether the employer will be requiring employee contributions to pay for the insurance, the employer completes one of the following forms:

- If you plan to take employee payroll deductions to pay for the cost of coverage: Employer’s Application for Voluntary Coverage (Employee Contribution Required) - Form PFL-136

Employer Responsibilities for Contributions

Employers are responsible for:

- Collecting employee payroll contributions
- Providing a waiver to employees who qualify for one (see below)
- Paying for Paid Family Leave insurance using the employee contributions
- Reporting employee contributions on tax Form W-2 using Box 14 – State disability insurance taxes withheld.

Payroll Deductions and Notice to Employees

- A public employer who has opted in to Paid Family Leave may begin collecting payroll contributions from their unrepresented employees upon providing 90 days’ notice.
- For employees who are represented by a union, their participation is subject to negotiation.

Opting Out/Waivers

Paid Family Leave is not optional for eligible employees. Coverage can only be waived if:

- the employee is regularly scheduled for less than 20 hours per week and will not work 175 days in a year, or
- the employee is regularly scheduled for 20 or more hours per week, but won’t be in employment 26 consecutive weeks. (Seasonal employees)

Contact Us

For more information, call the Paid Family Leave toll-free helpline Monday-Friday, 8:30am – 4:30pm EST.

Contact us by phone:

(844) 337-6303
NEW YORK STATE

Paid Family Leave

EMPLOYER'S APPLICATION FOR VOLUNTARY COVERAGE
for Class of Employees for Whom Paid Family Leave Benefits
are Not Required by Law (Employee Contribution Required)

Bureau of Compliance, 328 State Street, Schenectady, NY 12305

TO THE CHAIR, WORKERS' COMPENSATION BOARD

Name of Employer

Name Under Which Business is Conducted

Address

Federal Employer Identification Number (if no FEIN, give Social Security Number)

Telephone Number

Total Number of Employees

Class or classes of employees at the place or places of employment as follows

Number of employees in class or classes for whom paid family leave benefits are not required by law

A. The Employer represents that he or she ☐ is ☐ is not a covered employer within the definition thereof in Section 202 of the New York State Disability and Paid Family Leave Benefits Law.

B. The employer hereby gives notice of his/her election, under Section 212 of Law, to provide benefits to the extent and in the manner described below.

1. BENEFITS TO BE PROVIDED

☐ Paid family leave benefits as provided by a Plan to be filed under Section 211.

☐ Paid family leave benefits as provided under Section 204, if there is no Plan for such employees.

2. METHOD OF PROVIDING BENEFITS

☐ Insurance. Certificate to be filed as required.

☐ Self-Insurance, subject to approval of the Chair.

C. The employer agrees that:

1. Payment of benefits will be provided for a period of at least one year, and thereafter unless and until terminated as provided in item C-2.

2. At least ninety (90) days (or 12 months for public employers) prior written notice that the employer wishes to discontinue coverage will be given to the Chair and to the covered employees; and provision will be made for the payment of obligations incurred on and prior to the effective termination date, including a ratable part of assessments for the current period, all subject to approval of the Chair.

D. The employer hereby certifies that:

1. More than one-half of the employees for the class herein for whom benefits are to be provided have agreed to contribute to the cost of providing the benefits.

2. The agreement of such employees was made in writing or by election held on _______________ and upon 30 days' notice to the employees.

3. The contribution of each employee is at the rate of _______________ said rate being less than or equivalent to the current maximum contribution as set by the Department of Financial Services.

PLEASE COMPLETE REQUIRED INFORMATION ON REVERSE

PFL-136 (10-17)
I hereby affirm, under penalties of perjury, that I am ____________________________ of the above named employer; that I have carefully read the foregoing application, including attachments, and that the facts therein stated are true.

Date Signed ____________________________

Signature of Owner, Partner or Authorized Official

Telephone Number ____________________________

Name and Title ____________________________

CERTIFICATE OF EMPLOYEE REPRESENTATIVE(S)

The undersigned authorized representative(s) of employees covered by this application hereby certifies (certify) that more than one-half of such employees has duly agreed to contribute to the cost of paid family leave benefits as described herein.

Date Signed ____________________________

Signature of Employee Representative

Telephone Number ____________________________

Title ____________________________

Name of Employee Association or Union

Date Signed ____________________________

Signature of Employee Representative

Telephone Number ____________________________

Title ____________________________

Name of Employee Association or Union
Paid Family Leave

HOW TO APPLY FOR PAID FAMILY LEAVE

STEP 1: COMPLETE FORM PFL-1
- Complete PFL-1, Part A.
- Provide PFL-1 to employer.
- Employer completes PFL-1, Part B and returns to you within 3 days.

STEP 2: COLLECT SUPPORTING DOCUMENTATION

BOND
TO BOND WITH A NEWLY BORN, ADOPTED, OR FOSTERED CHILD
Complete Form PFL-2
- Complete PFL-2 and collect supporting documentation.

CARE
TO CARE FOR A FAMILY MEMBER WITH A SERIOUS HEALTH CONDITION
Complete Form PFL-3
- Care recipient completes PFL-3 and provides to health care provider. Care recipient's health care provider keeps PFL-3 on file.

Complete Form PFL-4
- Complete “Employee” information at the top of PFL-4. Provide PFL-4 to care recipient's health care provider. Care recipient's health care provider completes PFL-4 and returns to you.

ASSIST
TO ASSIST FAMILY MEMBERS DUE TO ANOTHER FAMILY MEMBER'S ACTIVE MILITARY DUTY OR IMPENDING ACTIVE DUTY ABROAD
Complete Form PFL-5
- Complete PFL-5 and collect supporting documentation.

STEP 3: SEND FORMS AND DOCUMENTS
- Send completed forms and supporting documentation to insurance carrier at the address provided in the PFL-1 Form Part B, Question 13 (the section your employer completed), or directly to your employer if they are self-insured.
- Insurance carrier accepts or denies claim within 18 days.
- You do not need to wait for this decision to start your leave.

Please keep a copy of all pages for your records.
For more information, forms, and instructions, visit www.ny.gov/PaidFamilyLeave or call (844) 337-6303.
Request For Paid Family Leave (Form PFL-1) Instructions

- To request PFL, the employee requesting PFL must complete 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 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 leave being requested. The employee requesting leave is responsible for the completion of these forms.

- 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 their records.

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

The employee requesting PFL must complete all required information.

#### Paid Family Leave (PFL) Request (to be completed by the employee)

**Question 12:** A child is defined as a biological, adopted, or foster son or daughter, a stepson or stepdaughter, a legal ward, a son or daughter of a domestic partner, or the person to whom the employee stands in loco parentis. A parent is defined as a biological, foster, or adoptive parent, parent-in-law, a stepparent, a legal guardian, or other person who stood in loco parentis to the employee when the employee was a child.

**Questions 13:** If dates are “Continuous”, 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 and indicate “Dates are estimated”. If dates are “Periodic”, enter the dates PFL will be taken. Please be as specific as possible. If the dates are unknown or estimated, indicate “Dates are estimated”.

If dates are estimated, the PFL carrier may require you to submit a request for payment after the PFL day is taken. Payment for approved claims will be due as soon as possible but in no event more than 18 days from the date of the completed request.

**Question 14:** If the employee is submitting the PFL request to their 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 their date of birth at the top of the attachment.

### Employment Information (to be completed by the employee)

**Question 16:** 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 18:** Enter the best estimate of average gross weekly wage. Include only the wages earned from the employer listed on this request form. The gross weekly wage is the 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 their 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:**

<table>
<thead>
<tr>
<th>Step</th>
<th>Description</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>Week 1</td>
<td>Gross wage including overtime</td>
<td>$550</td>
</tr>
<tr>
<td>Week 2</td>
<td>Gross wage</td>
<td>$500</td>
</tr>
<tr>
<td>Week 3</td>
<td>Gross wage</td>
<td>$500</td>
</tr>
<tr>
<td>Week 4</td>
<td>Gross wage</td>
<td>$500</td>
</tr>
<tr>
<td>Week 5</td>
<td>Gross wage</td>
<td>$500</td>
</tr>
<tr>
<td>Week 6</td>
<td>Gross wage</td>
<td>$500</td>
</tr>
<tr>
<td>Week 7</td>
<td>Gross wage, including overtime</td>
<td>$550</td>
</tr>
<tr>
<td>Week 8</td>
<td>Gross wage, including overtime</td>
<td>$550</td>
</tr>
<tr>
<td>Total</td>
<td></td>
<td>$4,200</td>
</tr>
</tbody>
</table>

Divide by 8

Average Weekly Wage = $525

Bonus earned in preceding 52 weeks = $2,600

Divide by 52

Prorated Weekly Bonus = $50

*Form PFL-1 Instructions continued on next page*
PART A - EMPLOYEE INFORMATION
(to be completed by the employee) - continued from prior page

<table>
<thead>
<tr>
<th>Form PFL-1 Instructions continued from prior page</th>
</tr>
</thead>
<tbody>
<tr>
<td>Average Weekly Wage</td>
</tr>
<tr>
<td>Prorated Weekly Bonus</td>
</tr>
<tr>
<td><strong>Average Weekly Wage (including bonus)</strong></td>
</tr>
</tbody>
</table>

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).

If you are pre-submitting form: Indicate if the employee is pre-submitting their PFL request. Pre-submitting 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 submitting. If pre-submitting is permitted by the carrier

Employee signs and dates, before giving this form to their employer to complete Part B.

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

| Question 2: If a Social Security Number is used for the Federal Employer Identification Number (FEIN), enter the Social Security Number. |
| Question 3: Enter the employer's Standard Industrial Classification (SIC) Code. Contact your carrier if you don't know your SIC code. |
| Question 8: The employee occupation code can be found at: www.bls.gov/soc/2018/major_groups.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 18 starting on page 1 of the instructions.) Calculate the gross average weekly wage by adding up the gross amounts paid, and then divide by eight (or number of weeks worked if less than eight). |
| Affirmation employee is eligible for PFL: An employee who regularly works 20 hours or more per week must have been in employment for at least 26 consecutive weeks. An employee who regularly works less than 20 hours per week must have worked 175 days. |

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

Be sure to complete the appropriate additional PFL form(s) based on the type of PFL leave being requested.

---


The Workers' Compensation Board's (Board's) authority to request that employees provide personal information, including their social security number or tax identification number, is derived from the Board's administrative authority under Workers' Compensation Law section 142. This information is collected to assist the Board in investigating and administering claims in the most expeditious manner possible and to help it maintain accurate records. Providing your social security number or tax identification number to the Board is voluntary. The Board will protect the confidentiality of all personal information in its possession, disclosing it only in furtherance of its official duties and in accordance with applicable state and federal law.

Form PFL-1 Instructions
Page 2 of 2

If you need assistance, please call (844) 337-6303
www.ny.gov/PaidFamilyLeave
### Request For Paid Family Leave (Form PFL-1)

**PART A - EMPLOYEE INFORMATION (to be completed by the 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
   - Street 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 primary telephone number
   - ( )

7. Employee's preferred email address while on PFL (if available)

8. Employee's gender
   - [ ] Male
   - [ ] Female
   - [ ] Not designated/Other

9. Employee's preferred language
   - [ ] English
   - [ ] Español
   - [ ] Русский
   - [ ] Polski
   - [ ] 中文
   - [ ] Italiano
   - [ ] Kreyòl ayisyen
   - [ ] 한국어
   - [ ] Other

---

<table>
<thead>
<tr>
<th>Reason for PFL request:</th>
<th>[ ] Bond with child</th>
<th>[ ] Care for family member</th>
<th>[ ] Military qualifying event</th>
</tr>
</thead>
</table>

12. The family member is employee's:
   - [ ] Child
   - [ ] Spouse
   - [ ] Domestic partner
   - [ ] Parent
   - [ ] Parent-in-law
   - [ ] Grandparent
   - [ ] Grandchild

Form PFL-1 continued on next page

---

If you need assistance, please call (844) 337-6303  
www.ny.gov/PaidFamilyLeave
FORM PFL-1 - CONTINUED FROM PRIOR PAGE

TO BE COMPLETED BY THE EMPLOYEE

Employee's name (first name, middle initial, last name)  Employee's date of birth (MM/DD/YYYY)

PART A - EMPLOYEE INFORMATION (to be completed by the employee) - continued from prior page

Form PFL-1 continued from prior page

13. Will PFL be for a continuous period of time and/or periodic?

☐ Continuous  PFL start date (MM/DD/YYYY)  PFL end date (MM/DD/YYYY)  ☐ Dates are estimated

☐ Periodic  Identify dates periodic PFL will be taken:  ☐ Dates are estimated

14. If providing less than 30 day's advance notice to the employer, please explain:

Employment Information (to be completed by the employee)

15. Business name

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

17. Employee's work location

Street address

City, State  Zip code  Country (if not U.S.A.)

18. Employee's average gross weekly wage (This data will be requested of both employee and employer)

19. Employer's telephone number for contact regarding this request ( )  -

20a. Does employee have more than one employer?  ☐ Yes  ☐ No

20b. If yes, is employee taking PFL from the other employer?  ☐ Yes  ☐ No

21. 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 any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

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)

☐ I am submitting this form in advance (see instructions about pre-submitting). I understand the insurance carrier will contact me to advise how to submit the required missing information.
TO BE COMPLETED BY THE EMPLOYEE

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

Employee's date of birth (MM/DD/YYYY)  

---

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

1. Business's full legal 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 Standard Industrial Classification (SIC) Code  

4. Employer's contact name for questions related to PFL  

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/ocd2018/maior_groups.htm  

9. Enter the last 8 weeks of gross wages for the employee and calculate the average gross weekly wage

<table>
<thead>
<tr>
<th>Week no.</th>
<th>Week ending date (MM/DD/YYYY)</th>
<th>Number of days worked</th>
<th>Gross amount paid</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>5</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>6</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>7</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>8</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Calculated average gross weekly wage:  

10. If employee received or will receive full wages while on PFL, will employer be requesting reimbursement?  

   □ Yes  □ No  

Form PFL-1 continued on next page
**TO BE COMPLETED BY THE EMPLOYEE**

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

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

---

**PART B - EMPLOYER INFORMATION** (to be completed by the employer) - continued from prior page

**Form PFL-1 continued from prior page**

11a. In the preceding 52 weeks has the employee taken leave for:  
- [ ] NYS Disability  
- [ ] PFL  
- [ ] Both Disability and PFL  
- [ ] None

11b. Enter the total number of weeks and days taken for both Disability and PFL in the last 52 weeks:

<table>
<thead>
<tr>
<th>Disability:</th>
<th>Please provide specific dates for Disability:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Weeks</td>
<td></td>
</tr>
<tr>
<td>Days</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>PFL:</th>
<th>Please provide specific dates for PFL:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Weeks</td>
<td></td>
</tr>
<tr>
<td>Days</td>
<td></td>
</tr>
</tbody>
</table>

12. **Is the employee taking Family Medical Leave Act (FMLA) concurrently with PFL?**  
- [ ] Yes  
- [ ] No

13. **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.)

14. **PFL insurance carrier’s telephone number**

   - (___) ___-___

15. **PFL policy number**

---

**Declaration and signature**

- [ ] I affirm the employee regularly works 20 or more hours per week and has been in employment for at least 26 consecutive weeks OR the employee regularly works less than 20 hours per week and has worked at least 175 days.

Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

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**

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

---

**Title**
Bonding Certification (Form PFL-2) Instructions

If the employee is requesting PFL to bond with a newborn, an 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. Send completed forms and supporting documentation to insurance carrier.

If this form is being submitted in advance (pre-submitting) and some information is unknown, the insurance carrier will contact the employee and explain how to provide the required additional information.

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

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

Question 5: See chart below for documentation details. Unless specified, do not send the original documents.

<table>
<thead>
<tr>
<th>Bonding Form/Certification</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Health care provider certification of pregnancy</td>
<td>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.</td>
</tr>
<tr>
<td>Health care provider certification of birth</td>
<td>An original letter obtained from the birth mother's health care provider that includes the mother's name and child's date of birth.</td>
</tr>
<tr>
<td>Birth Certificate</td>
<td>A copy of the certificate issued by the city or county office in which the child is born.</td>
</tr>
<tr>
<td>Voluntary Acknowledgment of Paternity (Form LDSS-4418)</td>
<td>A copy of the form that establishes legal fatherhood when the parents are unmarried. Completed by both mother and father. For more information, see <a href="http://childsupport.ny.gov/dcae/aop_howto.html">childsupport.ny.gov/dcae/aop_howto.html</a></td>
</tr>
<tr>
<td>Court Order of Filiation</td>
<td>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 <a href="http://childsupport.ny.gov/dcae/aop_howto.html">childsupport.ny.gov/dcae/aop_howto.html</a></td>
</tr>
<tr>
<td>Marriage Certificate</td>
<td>A copy of the official statement issued by the town or city clerk from which the marriage certificate was issued.</td>
</tr>
<tr>
<td>Civil union/domestic partner's documentation</td>
<td>A copy of the certificate of civil union or domestic partnership.</td>
</tr>
<tr>
<td>Foster care placement letter</td>
<td>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.</td>
</tr>
<tr>
<td>Court documents of adoption</td>
<td>A copy of the court document finalizing adoption or documentation in furtherance or court order finalizing adoption.</td>
</tr>
<tr>
<td>Other documentation</td>
<td>Other documentation of parental relationship may be accepted if none of the others listed apply.</td>
</tr>
</tbody>
</table>

Notification Pursuant to the New York Personal Privacy Protection Law (Public Officers Law Article 6-A) and the Federal Privacy Act of 1974 (5 USC 552a).

The Workers' Compensation Board's (Board's) authority to request that employees provide personal information, including their social security number or tax identification number, is derived from the Board's administrative authority under Workers' Compensation Law section 142. This information is collected to assist the Board in investigating and administering claims in the most expedient manner possible and to help it maintain accurate records. Providing your social security number or tax identification number to the Board is voluntary. The Board will protect the confidentiality of all personal information in its possession, disclosing it only in furtherance of its official duties and in accordance with applicable state and federal law.

Form PFL-2 Instructions
Page 1 of 1

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

DO NOT SCAN
# Request For Paid Family Leave
## Bonding Certification (Form PFL-2)

**INSTRUCTIONS INCLUDED WITH FORM**

### TO BE COMPLETED BY THE EMPLOYEE

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

---

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

---

**Employee's Social Security Number or TIN**

---

**Employee's mailing address**

---

- **Mailing address**

---

- **City, State**

---

- **Zip code**

---

- **Country (if not U.S.A.)**

### BONDING CERTIFICATION (to be completed by the employee)

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

---

2. **Child's gender**
   - [ ] Male
   - [ ] Female
   - [ ] Not designated/Other

3. **Does child live with the employee requesting PFL?**
   - [ ] Yes
   - [ ] No

4. **Child is employee's:**
   - [ ] Biological child
   - [ ] Stepchild
   - [ ] Foster child
   - [ ] Adopted child
   - [ ] Legal ward
   - [ ] Spouse/Domestic partner's child
   - [ ] Loco parentis

5. **Select one of the following and attach the document as required as evidence of the relationship.**

   **Parent of newborn child:**
   - [ ] 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 child AND mother's name); OR
   - [ ] Child's birth certificate

   **Other parent:**
   - [ ] Copy of birth certificate naming second parent; OR
   - [ ] 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
     - [ ] Evidence of domestic partnership
   - [ ] OR; Other documentation of parental relationship

   **Foster parent:**
   - [ ] Letter of foster care placement or anticipated 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

6. **Date of foster care or adoption placement, if applicable** (MM/DD/YYYY)

---

*Form PFL-2 continued on next page*
### TO BE COMPLETED BY THE EMPLOYEE

<table>
<thead>
<tr>
<th>Employee’s name (first name, middle initial, last name)</th>
<th>Employee’s date of birth (MM/DD/YYYY)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### BONDING CERTIFICATION (to be completed by the employee) - continued from prior page

**Declaration and signature**

Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

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.

<table>
<thead>
<tr>
<th>Employee’s signature</th>
<th>Date signed (MM/DD/YYYY)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Release Of Personal Health Information Under
The Paid Family Leave Law (Form PFL-3) Instructions

- 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 their 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.

- 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.

- The employee requesting PFL submits both the Request For Paid Family Leave (Form PFL-1) and the Health Care Provider Certification For Care Of Family Member With Serious Health Condition (Form PFL-4) to their employer’s PFL insurance carrier, or to their employer if the employer is self-insured, for PFL benefit determination.

NOTE: This form will be retained by the health care provider. The employee should make a copy for their records before giving it to the health care provider.

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).

---

RElease of PERSONal HEALTH INFORMATION BY the HEALTH CARE PROVIDER FOR a FAMILY MEMBER WITH A SERIOUS HEALTH CONDITION (to be completed by the care recipient or authorized representative and submitted to care recipient’s health care provider with Form PFL-4)

Employee enters their name, and care recipient’s (patient’s) name and date of birth at the top of each page.

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 13.

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.

---

Notification Pursuant to the New York Personal Privacy Protection Law (Public Officers Law Article 6-A) and the Federal Privacy Act of 1974 (5 USC 552a).

The Workers’ Compensation Board’s (Board’s) authority to request that employees provide personal information, including their social security number or tax identification number, is derived from the Board’s administrative authority under Workers’ Compensation Law section 147. This information is collected to assist the Board in investigating and administering claims in the most expeditious manner possible and to help maintain accurate records. Providing your social security number or tax identification number to the Board is voluntary. The Board will protect the confidentiality of all personal information in its possession, disclosing it only in furtherance of its official duties and in accordance with applicable state and federal law.

Form PFL-3 Instructions
Page 1 of 1

If you need assistance, please call (844) 337-6303
www.ny.gov/PaidFamilyLeave
Request For Paid Family Leave
Release Of Personal Health Information
Under The Paid Family Leave Law (Form PFL-3)

TO BE COMPLETED BY THE EMPLOYEE

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

__________________________________________________________

Care recipient's (patient's) name (first name, middle initial, last name)

__________________________________________________________

Care recipient's (patient's) date of birth (MM/DD/YYYY)

__/__/____

RELEASE OF PERSONAL HEALTH INFORMATION BY THE HEALTH CARE PROVIDER FOR A FAMILY MEMBER
WITH A SERIOUS HEALTH CONDITION (to be completed by the care recipient or authorized representative and
submitted to care recipient's health care provider with Form PFL-4)

I, ____________________________, authorize my health care provider listed on this form to

release my personal health information to ____________________________, and their

employer's PFL insurance carrier ____________________________.

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.

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 (to be completed by the care recipient or authorized representative)

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.

1. Health care provider's name

__________________________________________________________

2. Health care provider's mailing address

Mailing address

City, State Zip code Country (if not U.S.A.)

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

__________________________________________________________

Form PFL-3 continued on next page
**TO BE COMPLETED BY THE EMPLOYEE**

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

<table>
<thead>
<tr>
<th>Care recipient's (patient's) name (first name, middle initial, last name)</th>
<th>Care recipient's (patient's) date of birth (MM/DD/YYYY)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**RELEASE OF PERSONAL HEALTH INFORMATION BY THE HEALTH CARE PROVIDER FOR A FAMILY MEMBER WITH A SERIOUS HEALTH CONDITION** (to be completed by the care recipient or authorized representative and submitted to care recipient's health care provider with Form PFL-4) - continued from prior page

**Form PFL-3 continued from prior page**

**Care Recipient Information** (to be completed by the care recipient or authorized representative)

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

<table>
<thead>
<tr>
<th>Mailing address</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>City, State</th>
<th>Zip code</th>
<th>Country (if not U.S.A.)</th>
</tr>
</thead>
</table>

5. **Care recipient's Social Security Number**

   |   |   |   |

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

   |   |   |   |

**READ AND SIGN BELOW**

I hereby request that the health care provider listed give a completed Health Care Provider Certification For Care Of Family Member With Serious Health Condition (Form PFL-4) to the employee identified on the PFL-4 form. 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**

<table>
<thead>
<tr>
<th>Date signed (MM/DD/YYYY)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
</tr>
</tbody>
</table>

**Authorized representative**

<table>
<thead>
<tr>
<th>Print name</th>
</tr>
</thead>
</table>

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

- [ ] Parental right
- [ ] Power of attorney (attach copy)
- [ ] Court order (attach copy)
- [ ] Health care proxy (attach copy)

**Authorized representative's signature**

<table>
<thead>
<tr>
<th>Date signed (MM/DD/YYYY)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
</tr>
</tbody>
</table>

The employee should retain a copy for their own records.
Health Care Provider Certification For Care Of Family Member With Serious Health Condition (Form PFL-4) Instructions

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:

- Employee enters their name, date of birth, other last names, if any, under which they have worked, Social Security or Taxpayer Identification Number (TIN) number, mailing address, and care recipient's (patient's) name and date of birth at the top of page 1.
- Employee enters their name and date of birth, and care recipient's (patient's) name and date of birth at the top of page 2.
- Employee gives the Health Care Provider Certification For Care Of Family Member With Serious Health Condition (Form PFL-4) to the health care provider.

HEALTH CARE PROVIDER CERTIFICATION FOR CARE OF FAMILY MEMBER WITH SERIOUS HEALTH CONDITION
(to be completed by the health care provider for the care recipient (patient) and returned to the employee identified above)

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

Patient Information / family member with serious health condition (to be completed by the health care provider for the care recipient (patient) and returned to the employee identified above)

Question 2: Providing the optional ICD-10 code is recommended.

The patient'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 patient is the victim of abuse or neglect caused by the employee requesting PFL, you may decline to provide this certification.

Employee:

- When you receive the completed Health Care Provider Certification For Care Of Family Member With Serious Health Condition (Form PFL-4) form from the health care provider, send the completed forms and supporting documentation to the insurance carrier.

Notification Pursuant to the New York Personal Privacy Protection Law (Public Officers Law Article 6-A) and the Federal Privacy Act of 1974 (5 USC 552a).

The Workers' Compensation Board's (Board's) authority to request that employees provide personal information, including their social security number or tax identification number, is derived from the Board's administrative authority under Workers' Compensation Law section 142. This information is collected to assist the Board in investigating and administering claims in the most expedient manner possible and to help it maintain accurate records. Providing your social security number or tax identification number to the Board is voluntary. The Board will protect the confidentiality of all personal information in its possession, disclosing it only in furtherance of its official duties and in accordance with applicable state and federal law.
**Request For Paid Family Leave**

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

INSTRUCTIONS INCLUDED WITH FORM

**TO BE COMPLETED BY THE EMPLOYEE**

**Employee’s name** (first name, middle initial, last name)

**Employee’s date of birth** (MM/DD/YYYY)

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

**Employee’s Social Security Number or TIN**

**Employee’s mailing address**

<table>
<thead>
<tr>
<th>Mailing address</th>
<th></th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>City, State</th>
<th>Zip code</th>
<th>Country (if not U.S.A.)</th>
</tr>
</thead>
</table>

**Care recipient’s (patient’s) name** (first name, middle initial, last name)

**Care recipient’s (patient’s) date of birth** (MM/DD/YYYY)

<p>| | | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
</table>

**HEALTH CARE PROVIDER CERTIFICATION FOR CARE OF FAMILY MEMBER WITH SERIOUS HEALTH CONDITION** (to be completed by the health care provider for the care recipient (patient) and returned to the employee identified above)

Patient Information / family member with serious health condition (to be completed by the health care provider for the care recipient (patient) and returned to the employee identified above)

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

   **Note:** 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.

2. **Primary ICD-10 code (optional)**

   |  |  |  |  |  |  |  |  |

3. **Diagnosis**

   ____________________________________________________________

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

   |  |  |  |

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

   |  |  |  |

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

   |  |  |  |

7. **Estimated number of days per week OR days per month patient requires care**

   - Days/week
   - OR
   - Days/month

Health Care Provider Information (to be completed by the health care provider for the care recipient (patient) and returned to the employee identified above)

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

   ____________________________________________________________

---

Form PFL-4 continued from prior page
TO BE COMPLETED BY THE EMPLOYEE

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

Employee's date of birth (MM/DD/YYYY)  

Care recipient's (patient's) name (first name, middle initial, last name)  

Care recipient's (patient's) date of birth (MM/DD/YYYY)  

HEALTH CARE PROVIDER CERTIFICATION FOR CARE OF FAMILY MEMBER WITH SERIOUS HEALTH CONDITION  
(to be completed by the health care provider for the care recipient (patient) and returned to the employee identified above)  
continued from prior page

Form PFL-4 continued from prior page

9. Type of health care provider:

☐ Medical Doctor (MD)  ☐ Dentist (DDS/DDM)  ☐ Licensed Social Worker (LMSW/LCSW)
☐ Doctor of Osteopathy (DO)  ☐ Physician's Assistant (PA)  ☐ Other (specify)
☐ Doctor of Podiatric Medicine (DPM)  ☐ Nurse Practitioner (NP)  
☐ Doctor of Chiropractic Medicine (DC)  ☐ Licensed Psychologist  

10. Health care provider's mailing address

Mailing address  

City, State  Zip code  Country (if not U.S.A.)

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

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

13. Health care provider's email address (if available)

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

15. Specialty

16. Health care provider's license number

Certification and signature

Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

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)
Military Qualifying Event (Form PFL-5) Instructions

If an employee is requesting PFL because of a family member’s covered active military duty or impending covered 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, provide a copy of the member’s covered active duty orders or impending active 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 their name, date of birth, other last names, if any, under which they have worked, Social Security or Taxpayer Identification Number (TIN) number, and mailing address at the top of page 1.

Employee enters their name and date of birth at the top of page 2.

Questions 1-5: Enter the military member’s information, and indicate the military member’s relationship to the employee.

Question 5: A child is defined as a biological, adopted, or foster son or daughter, a stepson or stepdaughter, a legal ward, a son or daughter of a domestic partner, or the person to whom the employee stands in loco parentis. A parent is defined as a biological, foster, or adoptive parent, parent-in-law, a stepparent, a legal guardian, or other person who stood in loco parentis to the employee when the employee was a child.

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 has been notified of an impending call or order 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 from the military unit documenting impending call or order to covered duty; OR
- Documentation of military leave signed by the approving authority for military member’s Rest and Recuperation.

### Qualifying Reason for Leave (to be completed by the employee)

**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, date of birth, other last names, if any, under which they have worked, Social Security or Taxpayer Identification Number (TIN) number, and mailing address 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.

Notification Pursuant to the New York Personal Privacy Protection Law (Public Officers Law Article 6-A) and the Federal Privacy Act of 1974 (5 USC 552a).

The Workers’ Compensation Board’s (Board’s) authority to request that employees provide personal information, including their social security number or tax identification number, is derived from the Board’s administrative authority under Workers’ Compensation Law section 142. This information is collected to assist the Board in investigating and administering claims in the most expedient manner possible and to help it maintain accurate records. Providing your social security number or tax identification number to the Board is voluntary. The Board will protect the confidentiality of all personal information in its possession, disclosing it only in furtherance of its official duties and in accordance with applicable state and federal law.

Form PFL-5 Instructions
Page 1 of 1

If you need assistance, please call (844) 337-8303
www.ny.gov/paidfamilyleave

DO NOT SCAN
# Request For Paid Family Leave

**Military Qualifying Event (Form PFL-5)**

**INSTRUCTIONS INCLUDED WITH FORM**

## TO BE COMPLETED BY THE EMPLOYEE

<table>
<thead>
<tr>
<th>Field</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Employee's name</td>
<td>(first name, middle initial, last name)</td>
</tr>
<tr>
<td>Other last names</td>
<td>if any, under which employee has worked</td>
</tr>
<tr>
<td>Employee's mailing address</td>
<td></td>
</tr>
<tr>
<td>Mailing address</td>
<td></td>
</tr>
<tr>
<td>City, State</td>
<td></td>
</tr>
<tr>
<td>Zip code</td>
<td></td>
</tr>
<tr>
<td>Country (if not U.S.A.)</td>
<td></td>
</tr>
</tbody>
</table>

## MILITARY QUALIFYING EVENT (to be completed by the employee)

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

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

3. **Military member's gender**
   - [ ] Male
   - [ ] Female
   - [ ] Not designated/Other

4. **Military member's mailing address**
   | Mailing address |  |
   | City, State |  |
   | Zip code |  |
   | Country (if not U.S.A.) |  |

5. **The above-named military member is employee’s:**
   - [ ] Spouse
   - [ ] Domestic partner
   - [ ] Child
   - [ ] 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 or order to covered active duty status:**
   - [ ] Covered active duty orders
   - [ ] Letter of impending call or order to covered duty
   - [ ] Documentation of military leave signed by the approving authority for military member’s Rest and Recuperation

## Qualifying Reason For Leave (to be completed by the employee)

8. **What is the reason employee is requesting PFL? (One or more reasons may be selected.)**
   - [ ] Arranging for child care
   - [ ] Arranging for parental care
   - [ ] Counseling
   - [ ] Making financial arrangements
   - [ ] Making legal arrangements
   - [ ] Acting as military member’s representative before a federal, state, or local agency for purpose of obtaining, arranging, or appealing military service benefits
   - [ ] Attending any event sponsored by the military or military service organizations
   - [ ] Other

---

Form PFL-5 continued on next page
TO BE COMPLETED BY THE EMPLOYEE

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

Employee's date of birth (MM/DD/YYYY)

MILITARY QUALIFYING EVENT (to be completed by the employee) - continued from prior page

Form PFL-5 continued from prior page

9. Written documentation supporting this request for leave is available and attached?

☐ Yes  ☐ No  ☐ None Available

Note: 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. If leave is requested to meet with a third party, the employee must provide the supporting documentation of the meeting that includes the name, address, appropriate contact information of the individual or entity with whom you are meeting (i.e., either telephone number, fax number, or email address of the individual or entity).

Declaration and signature

Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

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)
TO BE COMPLETED BY THE EMPLOYEE

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

Employee's date of birth (MM/DD/YYYY)

Other last names, if any, under which employee has worked

Employee's Social Security Number or TIN

Employee's mailing address

Mailing address

City, State

Zip code

Country (if not U.S.A.)

QUALIFYING REASON FOR LEAVE - DOCUMENTATION

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.

Please submit this documentation for each required meeting/event.

Name of individual with whom employee is meeting

Title

Organization

Telephone number (provide area or country code)

Fax number (provide area or country code)

Email address

Mailing address

Mailing address

City, State

Zip code

Country (if not U.S.A.)

Describe nature of meeting. Include dates, if known:
IF YOU NEED TO TAKE TIME OFF FROM WORK TO CARE FOR A FAMILY MEMBER,
YOU MAY BE ENTITLED TO PAID FAMILY LEAVE BENEFITS

Paid Family Leave is employee-funded insurance that provides job-protected, paid time off to:

- Bond with a newly born, adopted or fostered child;
- Care for a family member with a serious health condition; or
- Assist loved ones when a spouse, domestic partner, child or parent is called to active military service abroad.

Eligibility:

- Employees with a regular work schedule of 20 or more hours per week are eligible after 26 consecutive weeks of employment.
- Employees with a regular work schedule of less than 20 hours per week are eligible after 175 days worked.

Citizenship or immigration status is not a factor in your eligibility.

Benefits: In 2019, you can take up to 10 weeks of Paid Family Leave and receive 55% of your average weekly wage, capped at 55% of the New York State average weekly wage. Generally, your average weekly wage is the average of your last eight weeks of pay prior to starting Paid Family Leave.

Rights and Protections:

- **Job Protection:** Return to the same or comparable job after you take leave.
- You keep your health insurance while on leave (you may have to continue paying your portion of the premium costs, if any).
- Your employer is prohibited from discriminating or retaliating against you for requesting or taking Paid Family Leave.
- You do not have to exhaust sick leave or vacation accruals before using Paid Family Leave.

Paid Family Leave Request Process:

1. Notify your employer at least 30 days in advance, if foreseeable, or as soon as possible.
2. Complete and submit the Request for Paid Family Leave (Form PFL-1) to your employer.
3. Complete and attach the additional forms as required and submit to the insurance carrier listed below within 30 days of starting your leave, to avoid losing benefits.
4. In most cases, the insurance carrier must pay or deny benefits within 18 calendar days of receiving your completed request or your first day of leave, whichever is later.

You may obtain all forms from your employer, their insurance carrier listed below or online at PaidFamilyLeave.ny.gov/Forms.

Disputes:

If your Paid Family Leave claim is denied, you may request to have the denial reviewed by a neutral arbitrator. The insurance carrier listed below will provide you with information about requesting arbitration.

Discrimination Complaints:

If your employer terminates your employment, reduces your pay and/or benefits, or disciplines you in any way as a result of you requesting or taking Paid Family Leave, you may request to be reinstated by taking these steps:

1. Complete the Formal Request for Reinstatement Regarding Paid Family Leave (Form PFL-DC-119)
2. Send your completed form to your employer and a copy of the completed form to: Paid Family Leave, P.O. Box 9030, Endicott, NY 13761-9030
3. If your employer does not reinstate you or take other corrective action within 30 days, you may file a discrimination complaint with the Workers’ Compensation Board using the Paid Family Leave Discrimination/Retaliation Complaint (Form PFL-DC-120), available at PaidFamilyLeave.ny.gov/Forms. The Workers’ Compensation Board will assemble your case and schedule a hearing.
4. There are other state and federal laws that protect employees from discrimination. Additional information is available at PaidFamilyLeave.ny.gov.

For more information, forms, and Instructions, visit PaidFamilyLeave.ny.gov or call (844)-337-6303.

This information is a simplified presentation of your rights as required by Section 229 of the Disability and Paid Family Leave Benefits Law. Your employer’s Paid Family Leave benefits insurance carrier is:

PREScribed BY THE CHAIR,
WORKERS’ COMPENsATION BOARD

PFL-271S (Revised as of October 2018)

NYS Paid Family Leave - PO Box 9030, Endicott NY 13761
PFL Helpline: (844) 337-6303 - PaidFamilyLeave.ny.gov
Committee: Government Operations

From: Leesa Perazzo

Subject CR - Honoring Joan Spelter on her 90th Birthday

Background Info:

Evaluation/Analysis

Recommendation
Committee: Government Operations
From: Ed Kosiur
Subject: Discussion - Liquor Store at 844 Albany Street

Background Info:

Evaluation/Analysis

Recommendation
TO: COUNCIL MEMBERS
FROM: Mayor Gary McCarthy
SUBJECT: Mohawk Harbor Large Vessel Dockage CFA

Background Information:

The project consists of constructing over 600 feet of vessel dockage to allow for larger boats to dock at the Harbor; and a public access easement will be completed as part of project which will improve public access to and along the canal. This project will increase access to the pedestrian trail from the waterfront at Mohawk Harbor with information and way finding signs to direct visitors to downtown attractions, events, restaurants and businesses, historic sites, and other points of interest.

Evaluation/Analysis:
The New York State Department of State Local Waterfront Revitalization Program (LWRP), Empire State Development and the New York State Canalway Grant Program allow municipalities to apply for funding as lead applicant for projects that increase economic development and enhance the quality of life in NYS communities. It appears that continued progress on the waterfront redevelopment project will drive further economic development. The City will seek NYS funding for eligible project costs, with the required minimum match/total match being provided by the project developer.

LEGISLATION WILL BE PREPARED BY ____________________________

Law
City of Schenectady, New York

Resolution No: __________

A Resolution Authorizing the Mayor to Apply to New York State for Funds for a Mohawk Harbor Vessel Dockage

WHEREAS, the City of Schenectady is the site of current economic investment by governmental agencies throughout New York State, with the State selecting it as the site for a casino on the banks of the Mohawk River; and

WHEREAS, the City has continued to find potential for even greater benefits, including economic growth and job creation, in connection with the development at the new Mohawk Harbor waterfront development; and

WHEREAS, in furtherance of these goals, the City has developed and elected to pursue constructing over 600 feet of vessel dockage, to allow for larger boats to dock at the Harbor; and a public access easement will be completed as part of project which will improve public access to and along the canal supporting the NYS grant priority “Celebrating the Bicentennial of the Erie Canal- Improving Public Waterfront Access for Canal Communities”; and

WHEREAS, the City, as the lead applicant on behalf of its partners, desires to obtain matching funds from the New York State Department of State Local Waterfront Revitalization Program:

NOW, THEREFORE BE IT

RESOLVED: the City Council does hereby authorize the Mayor, Gary R. McCarthy, to direct the submission of applications on behalf of the City of Schenectady and its partners, and in connection with obtaining funds for this project, to the New York State Department of State under the Environmental Protection Fund Local Waterfront Revitalization Program (EPF LWRP) for grant monies in order to defray total costs. The application will seek total eligible project costs in state funds with a minimum match of 15%, to be provided by the developer of the site.
Committee:  City Development & Planning

From:  Carl Falotico

Subject  Sidewalk Petitions Review

Background Info:

Evaluation/Analysis

Recommendation
Committee:  City Development & Planning

From:  Andrew Koldin

Subject  Sale of 38 Willow Avenue

Background Info:

Evaluation/Analysis

Recommendation
Committee: City Development & Planning  Committee Date: Monday, July 01, 2019

From: Andrew Koldin

Subject: Sale of 42 Cheltingham Avenue

Background Info:

Evaluation/Analysis

Recommendation
Committee:  City Development & Planning

Committee Date:  Monday, July 01, 2019

From:  Andrew Koldin

Subject  Sale of 354 Olean Street

Background Info:

Evaluation/Analysis

Recommendation
SCHENECTADY CITY COUNCIL
Legislative Request Form

Committee:  City Development & Planning
From:  Andrew Koldin
Subject  Sale of 454 Hegeman Street

Background Info:

Evaluation/Analysis

Recommendation
Committee: City Development & Planning

From: Andrew Koldin

Subject: Sale of 704 Craig Street

Background Info:

Evaluation/Analysis

Recommendation
Committee: City Development & Planning
From: Andrew Koldin
Subject: Sale of 802 Bridge Street

Background Info:

Evaluation/Analysis

Recommendation
Committee:  City Development & Planning  Committee Date:  Monday, July 01, 2019

From:  Andrew Koldin

Subject  Sale of 1018 Willett Street

Background Info:

Evaluation/Analysis

Recommendation
Committee: City Development & Planning

From: Andrew Koldin

Subject: Sale of 1307 Union Street

Background Info:

Evaluation/Analysis

Recommendation
Committee: Claims

From: Carl Falotico

Subject: Kearse v. City of Schenectady Claim

Background Info:

Evaluation/Analysis

Recommendation
Committee: Public Safety

Committee Date: Monday, July 01, 2019

From: John Polimeni

Subject: Discussion - Safety Features and Security in City Hall

Background Info:

Evaluation/Analysis

Recommendation