Family and Medical Leave Act Application Form

HR-BEN-028

Section 1 - Information and Instructions

The purpose of this form is to request a leave of absence under the Family and Medical Leave Act ("FMLA").

Please mail or fax a signed copy of the completed form to your Agency Human Resources Department or FMLA Coordinator 30 days prior to the start of your leave or as soon as possible. (MTAHQ and BSC Employees must forward completed forms to the BSC at fax#: 212-852-8700 or bscservice@mtabsc.org)

Eligible employees requesting a leave under the FMLA may request a copy of the applicable policy, and the application and Certification of Healthcare Provider form from their manager or the BSC Customer Management Center by calling 646-376-0123. The policies and forms can be downloaded from the BSC Portal (www.mtabsc.info). An employee must request FMLA leave 30 days prior to the start of the leave, unless such notice is not practicable, in which case, the employee must provide notice as soon as possible.

The FMLA provides eligible employees with up to 12 weeks of unpaid leave for the following reasons: (1) incapacity due to pregnancy, prenatal medical care or childbirth; (2) to care for a child after birth, or placement for adoption or foster care; (3) to care for a spouse, child, or parent who has a serious health condition; (4) for the employee's own serious health condition that makes them unable to perform their job; and (4) to address certain qualifying exigencies if a spouse, child or parent is on active duty or called to active duty in a foreign country. The FMLA also provides up to 26 weeks of leave to care for a covered service member who has a serious illness or injury under certain circumstances.

If your request for FMLA is for your own or a family member with a serious health condition, a medical certification is required. Therefore, please visit the BSC Portal (www.mtabsc.info) to download the applicable FMLA application and medical certification listed below:

a) HR-BEN-069 FMLA Employee Certification w/Application Form
b) HR-BEN-070 FMLA Family Member Certification w/Application Form
c) HR-BEN-071 FMLA Military Exigency Certification w/Application Form
d) HR-BEN-072 FMLA Military Service member Certification w/Application Form

*If you only wish to request an extension of your FMLA entitlement, only complete HR-BEN-028 form.

If you have any questions about FMLA leave, please contact the BSC at (646) 376-0123 or bscservice@mtabsc.org.

Section 2 - Employee Information

Print Name	Last		First		M.I. Suffix	BSC ID / Agency ID
Agency/Dept (check one)	☐ BSC	☐ B&T	☐ CC	☐ HQ	☐ Police	Department
	☐ SIR	☐ LIRR	☐ MNR	☐ MTA Bus	☐ NYCT	Job Title
					☐ MaBSTOA	Reg Work Sched
Street Address						
City					State	Zip Code
Phone (H)		Phone (W)				Email

Section 3 – Reason For Leave

Please Check only one:	
My own serious health condition renders me unable to perform the functions of my position.	☐
The birth of a child, or to care for a child within 12 months of date of birth.	☐
The placement with me of a child for adoption or foster care, or to care for a child	☐
To care for my ☐ spouse, ☐ child, or ☐ parent with a serious health condition. (Child's DOB:).	☐
Qualified exigency leave for my ☐ spouse, ☐ child, or ☐ parent on active duty or called to active duty in a foreign county	☐
To care for my ☐ spouse, ☐ child, ☐parent, or ☐ next of kin who is a covered service member with a serious injury or illness	☐

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HR-BEN-028

Section 4 – Request for Leave	
Leave beginning on	and leave ending on .
Total number of work days	or total number of work weeks

Section 5 – Type of Leave Requested

a) State the type of leave you are requesting: ☐ Intermittent ☐ Reduced Schedule ☐ Continuous

(Intermittent Leave is separate blocks of time due to a single qualifying reason. A reduced schedule leave is a leave schedule that reduces your usual number of working hours per workweek or hours per work day, and a continuous leave is taken in consecutive blocks of time.)

b) If Intermittent, or reduced schedule leave, state the schedule you are requesting:

Section 6 - Authorization

I do hereby certify that to the best of my knowledge the above information is true and correct.

I understand that fraudulently requesting, obtaining and/ or misusing this leave will be cause for disciplinary action, up to and including dismissal from employment.

Employee Signature	Date	SSN Last 4 Digits
Supervisor's Signature	Date	

For Agency Human Resources Use Only (check one):

☐ Meets Eligibility Requirements: ☐ Does Not Meet Eligibility Requirements:

Print Name	Signature	Date

FMLA Certification of Health Care Provider
Family Serious Health Conditions

HR-BEN-070

Section 1 – Instructions for EMPLOYEE

INSTRUCTIONS to the EMPLOYEE: Please complete Section 2 before giving this form to your family member or his/her medical provider. The FMLA permits an employer to require that you submit a timely, complete, and sufficient medical certification to support a request for FMLA leave to care for a covered family member with a serious health condition. If requested by your employer, your response is required to obtain or retain the benefit of FMLA protections. 29 U.S.C. §§ 2613, 2614(c)(3). Failure to provide a complete and sufficient medical certification may result in a denial of your FMLA request. 29 C.F.R. § 825.313. Your employer must give you at least 15 calendar days to return this form to your employer. 29 C.F.R. §825.305.

If you have any questions, please contact MTA Business Service Center (BSC) at 646-376-0123 or bscservice@mtabsc.org.

Section 2 - Employee Information

Print Name	Last	First		M.I. Suffix	BSC ID Agency ID
Agency/Dept. (check one)	☐ BSC	☐ B&T	☐ CC	☐ HQ	☐ Police
	☐ SIR	☐ LIRR	☐ MNR	☐ MTA Bus	☐ NYCT ☐ MaBSTOA

Department	
Job Title:	
Regular Work Schedule:	

Street Address		
City	State	Zip Code
Phone (H)	Phone (W)	Email
Name of Family Member for whom you will provide care:	Relationship of family member to you: ☐Parent ☐Spouse ☐Child If son or daughter, date of birth:	

Describe Care you will provide to your family member and estimate leave need to provide care:

Employee Signature	Date

Section 4 – For Completion by the HEALTH CARE PROVIDER

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

Provider's Name:	License Number:	State:
Type of Practice/Medical Specialty:		
Provider's Address:		
City	State	Zip
Phone	Fax	

FMLA Certification of Health Care Provider
Family Serious Health Conditions

HR-BEN-070

PART A: MEDICAL FACTS

1. What is the family member serious health condition?

2. Approximate date condition commenced: ____________________

   Probable duration of condition: ____________________

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

   ☐ No ☐ Yes If so, dates of admission: ____________________

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

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

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

   Was the patient referred to other health care provider(s) for evaluation or treatment (e.g., physical therapist)? ☐ No ☐ Yes. If so, state the nature of such treatments and expected duration of treatment:

3. Is the medical condition pregnancy? ☐ No ☐ Yes. If so, expected delivery date: ____________________

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

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

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

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

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

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

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

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

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

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

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

   __________hour(s) per day; ______________days per week from ____________________through ____________________

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

FMLA Certification of Health Care Provider
Family Serious Health Conditions

HR-BEN-070

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

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

Frequency: ___________times per ____week(s) _________________month(s)

Duration: __________hours or ________day(s) per episode

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

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

ADDITIONAL INFORMATION: IDENTIFY QUESTION NUMBER WITH YOUR ADDITIONAL ANSWER.

Section 5 – Signature of Health Care Provider	
I do hereby certify that to the best of my knowledge the above information is true and correct.	
Signature	Date

Section 6 – Agency Contact	
This Cerification form must be sent to your specific Agency representative. Below is a list of all of the Agency contacts. Please check the appropriate box next to your own Agency's contact.	
Please select only one box next to the appropriate Agency.	**Agency Name, Address, and Contact Information**
☐	**MTA & MTA Capital Construction** MTA Medical Department Occupational Health Services 420 Lexington Avenue, Suite 2201 New York, NY 10017 Attn: Nurse Manager
☐	**SIR** Human Resources Department 60 Bay St. Staten Island, NY 10301
☐	**LIRR** Human Resources Department 93-02 Sutphin Boulevard Jamaica, NY 11435
☐	**Metro-North Railroad** Administrator of Health Services MTA Metro-North Railroad Occupational Health Services Department 420 Lexington Avenue, 22nd Floor New York, NY 10017
☐	**NYCT/MaBSTOA** Occupational Health Services 180 Livingston St. Brooklyn, NY 11201