

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) | <input type="checkbox"/> BSC | <input type="checkbox"/> B&T | <input type="checkbox"/> CC | <input type="checkbox"/> HQ | <input type="checkbox"/> Police | | Department | | | |
| | <input type="checkbox"/> SIR | <input type="checkbox"/> LIRR | <input type="checkbox"/> MNR | <input type="checkbox"/> MTA Bus | <input type="checkbox"/> NYCT | | Job Title | | | |
| | | | | | <input type="checkbox"/> 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. | <input type="checkbox"/> |
| The birth of a child, or to care for a child within 12 months of date of birth. | <input type="checkbox"/> |
| The placement with me of a child for adoption or foster care, or to care for a child | <input type="checkbox"/> |
| To care for my <input type="checkbox"/> spouse, <input type="checkbox"/> child, or <input type="checkbox"/> parent with a serious health condition. (Child's DOB: _____). | <input type="checkbox"/> |
| Qualified exigency leave for my <input type="checkbox"/> spouse, <input type="checkbox"/> child, or <input type="checkbox"/> parent on active duty or called to active duty in a foreign county | <input type="checkbox"/> |
| To care for my <input type="checkbox"/> spouse, <input type="checkbox"/> child, <input type="checkbox"/> parent, or <input type="checkbox"/> next of kin who is a covered service member with a serious injury or illness | <input type="checkbox"/> |

FMLA Certification of Health Care Provider Employee's Serious Health Condition



HR-BEN-069

| Section 1 – For completion by the Employer (Employee Proceed to Section 2) | |
|--|------------------------|
| Employee's Job Title: | Regular Work Schedule: |
| Employee's Essential Job Functions: | |
| <input type="checkbox"/> Check is job description is attached. | |

| Section 2 - Instructions |
|---|
| Please complete Section 3 before giving this form to your health care 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 due to your own 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. 20 C.F.R. § 825.313. Your employer must give you at least 15 calendar days to return this form. 29 C.F.R. § 825.305(b). |

| Section 3 - Employee Information | | | | | | |
|----------------------------------|----------------------------------|-------------------------------|------------------------------|----------------------------------|---------------------------------|------------------------|
| Print Name | Last First M.I. Suffix | | | | | BSC ID |
| | | | | | | Agency ID |
| Agency/Dept. (check one) | <input type="checkbox"/> BSC | <input type="checkbox"/> B&T | <input type="checkbox"/> CC | <input type="checkbox"/> HQ | <input type="checkbox"/> Police | Department |
| | <input type="checkbox"/> SIR | <input type="checkbox"/> LIRR | <input type="checkbox"/> MNR | <input type="checkbox"/> MTA Bus | <input type="checkbox"/> NYCT | Job Title: |
| | <input type="checkbox"/> MaBSTOA | | | | | Regular Work Schedule: |
| Street Address | | | | | | |
| City | | | | State | Zip Code | |
| Phone (H) | | | Phone (W) | | | Email |

| Section 4 – For Completion by the HEALTH CARE PROVIDER | | |
|---|-----------------|--------|
| Your patient has requested leave under the FMLA. Answer, fully and completely, all applicable parts. Several questions seek a response as to the frequency or duration of a condition, treatment, etc. Your answer should be your best estimate based upon your medical knowledge, experience, and examination of the patient. Be as specific as you can; terms such as "lifetime," "unknown," or "indeterminate" may not be sufficient to determine FMLA coverage. Limit your responses to the condition for which the employee is seeking leave. 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 Employee's Serious Health Condition

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PART A: MEDICAL FACTS

1. What is the employee serious health condition?

2. Approximate date condition commenced: _____

Probable duration of condition: _____

Mark below as applicable:

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: _____

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

Was medication, other than over-the-counter medication, prescribed? 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. Use the information provided by the employer in Section II to answer this question. If the employer fails to provide a list of the employee's essential functions or a job description, answer these questions based upon the employee's own description of his/her job functions.

Is the employee unable to perform any of his/her job functions due to the condition? No Yes

If so, identify the job functions the employee is unable to perform:

5. Describe other relevant medical facts, if any, related to the condition for which the employee seeks leave (such medical facts may include symptoms, diagnosis, or any regimen of continuing treatment such as the use of specialized equipment)



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PART B: AMOUNT OF LEAVE NEEDED

6. Will the employee be incapacitated for a single continuous period of time due to his/her medical condition, including any time for treatment and recovery? No Yes

If so, estimate the beginning and ending dates for the period of incapacity: _____

7. Will the employee need to attend follow-up treatment appointments or work part-time or on a reduced schedule because of the employee's medical condition? No Yes

If so, are the treatments or the reduced number of hours of work medically necessary? 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:

Estimate the part-time or reduced work schedule the employee needs, if any:

_____hour(s) per day; _____days per week from _____through _____

8. Will the condition cause episodic flare-ups periodically preventing the employee from performing his/her job functions? No Yes

Is it medically necessary for the employee to be absent from work during the flare-ups? No Yes

If so, explain:

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

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

FMLA Certification of Health Care Provider Employee's Serious Health Condition



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| Section 6 – Agency Contact | |
|---|---|
| <p><i>This Certification 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.</i></p> | |
| Please select only one box next to the appropriate Agency. | Agency Name, Address, and Contact Information |
| <input type="checkbox"/> | <p>MTA & MTA Capital Construction MTA Medical Department Occupational Health Services 420 Lexington Avenue, Suite 2201 New York, NY 10017 Attn: Nurse Manager</p> |
| <input type="checkbox"/> | <p>SIR Human Resources Department 60 Bay St. Staten Island, NY 10301</p> |
| <input type="checkbox"/> | <p>LIRR Human Resources Department 93-02 Sutphin Boulevard Jamaica, NY 11435</p> |
| <input type="checkbox"/> | <p>Metro-North Railroad Administrator of Health Services MTA Metro-North Railroad Occupational Health Services Department 420 Lexington Avenue, 22nd Floor New York, NY 10017</p> |
| <input type="checkbox"/> | <p>NYCT/MaBSTOA Occupational Health Services 180 Livingston St. Brooklyn, NY 11201</p> |