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

HR-BEN-069

Section I – For completion by the Employee

INSTRUCTIONS to the EMPLOYEE: Please complete Section I 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).

Print Name	Last		First		M	Suffix	BSC ID:
Employer (check one)	☐ BSC	☐ B&T	☐ CC	☐ HQ	☐ Police	☐ MaBSTOA	Department:
	☐ SIR	☐ LIRR	☐ MNR	☐ MTA Bus	☐ NYCTA		
Street Address							
City					State		Zip Code
Phone (H)		Phone (W)			Email _____		

Section II – For completion by the Employer

Employee's Job Title:	Regular Work Schedule:
Employee's Essential Job Functions:	
☐ Check if job description is attached	

Section III – For Completion by the HEALTH CARE PROVIDER

Instructions to 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 Code:
Telephone:	Fax:	

PART A: MEDICAL FACTS

1. Approximate date condition commenced: _____

   Probable duration of condition: _____

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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:

_____

2. Is the medical condition pregnancy? ___No ___Yes If so, expected delivery date: _____

3. 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:

_____

4. 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):

_____

_____

_____

PART B: AMOUNT OF LEAVE NEEDED

5. 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: _____

6. 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 _____

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

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Section V – Agency Contact
This Medical 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.

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
☐	**LIRR** Human Resources Department 93-02 Sutphin Boulevard Jamaica, NY 11435
☐	**Metro-North Railroad** FMLA Administrator Human Resources 347 Madison Avenue, 4th Floor New York, NY 10017
☐	**Staten Island Railroad (SIR)** Human Resources Department 60 Bay Street Staten Island, NY 10301
☐	**NYCT / MaBSTOA / MTA BUS** Occupational Health Services 180 Livingston Street Brooklyn, NY 11201