Family Medical Leave Act (FMLA)
Certification for
Employee's Serious Health Condition

Massachusetts Bay Transportation Authority
Human Resources Department, FMLA Unit
10 Park Plaza, Room 4810, Boston, MA 02116
Phone 617-222-5751 Fax 617-222-3353

INSTRUCTIONS to the EMPLOYEE:

Please complete this section before giving this form to your medical provider. The FMLA (29 U.S.C. §§ 2613, 2614(c)(3) 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. Failure to provide a complete and sufficient medical certification may result in a denial of your FMLA request (20 C.F.R. § 825.313).

Name _____ Employee # _____ Area # _____

Address _____
NUMBER STREET CITY STATE ZIP

Home Phone _____ Date of Hire _____

Job Title _____ Full Time ☐ Part Time ☐

Essential Job Functions _____

Please circle scheduled days off - - SAT SUN MON TUE WED THUR FRI

VACATION RELIEF or LIST

Please check the qualifying reason for your FMLA request:

- ☐ **Employee's serious health condition (including prenatal conditions):**
- ☐ ***Maternity/Childbirth -** Estimated Date of Delivery _____
- ☐ ***Adoption/Foster Care -** Estimated Date of Event _____

*If I am applying for coverage for childbirth, adoption or foster care placement, I also am applying for any benefits I may be entitled to under the Massachusetts Maternity Leave (MML). If eligible for leave under FMLA, and/or the MML, I understand that the Authority shall apply any leave entitlement concurrently, unless otherwise designated by the Authority.

By signing this form I am authorizing the release of medical information related to my FMLA request to the Massachusetts Bay Transportation Authority.

Employee's Signature:_____ **Date:** _____

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INSTRUCTIONS to the HEALTH CARE PROVIDER:

Your patient/MBTA employee has requested leave under the FMLA. Please 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 employee. 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.

Patient/MBTA Employee Name: _____

Provider's name and business address: _____

Type of practice / Medical specialty: _____

Telephone: (_____)_____Fax:(_____)_____

PART A: MEDICAL FACTS

1. Approximate date condition commenced: _____

   Probable duration of condition: _____

   Mark below as applicable:
   Was the employee 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 employee for condition:

   _____

   Will the employee need to have treatment visits at least twice per year due to the condition?
   __No __Yes

   Has medication, other than over-the-counter medication, been prescribed? ___No ___Yes

   Has the employee been referred to other health care provider(s) for evaluation or treatment (e.g., physical therapist)? ___No ___Yes

   If so, please 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 MBTA to answer this question. If the MBTA has not provided a list of the employee's essential functions or a job description, please 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 from said treatment? ___No ___Yes

If so, please provide or 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 because of his/her medical condition and/or treatment? ___No ___Yes

If yes, 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 and/or unpredictable 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 yes, please explain:

_____

_____

Based upon your patient's medical history and your knowledge of the medical condition, please estimate the frequency of flare-ups and the duration of related incapacity that he/she 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 clarifying information:_____

ADDITIONAL INFORMATION: IDENTIFY QUESTION NUMBER WITH YOUR ADDITIONAL ANSWER.

_____

_____

_____

_____

_____

_____

_____

_____ _____

Signature of Health Care Provider **Date**