Family and Medical Leave Act Application Form

HR-BEN-028

Information and Instructions

If you wish to request a leave of absence under the Family and Medical Leave Act ("FMLA"), please complete this application form.

Please mail or fax a signed copy of the completed form to your Agency Human Resources Department 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 fostercare; (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 I - Employee Information

Print Name						BSC Employee ID:
	Last		First	M	Suffix	Agency Employee ID:
Employer (check one)	☐ MTA	☐ B&T	☐ CC	☐ NYCT		Department:
	☐ LIRR	☐ MNR	☐ MTA Bus	☐ LI Bus		Job Title:
Street Address						Regular Work Schedule:
City					State	Zip Code
Phone (H)		Phone (W)			Email	

Section II – 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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Section III – Request for Leave

a.) Leave Beginning on _____ and Leave Ending on _____

b.) Total # of Work Days _____ or Total # of Work Weeks _____

Section IV – Type of Leave

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 V – Employee Signature

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

Section VI – Supervisor Signature

Supervisor 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
Employee's Serious Health Condition

HR-BEN-069

Section I – For completion by the Employer (Employee Proceed to Section II)

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

Section II – 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						BSC Employee ID:
	Last		First	M	Suffix	Agency Employee ID:
Employer (check one)	☐ MTA	☐ B&T	☐ CC	☐ NYCT		Department:
	☐ LIRR	☐ MNR	☐ MTA Bus	☐ LI Bus		Job Title:
Street Address						Regular Work Schedule:
City					State	Zip Code
Phone (H)		Phone (W)			Email	

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:	

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

HR-BEN-069

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):

_____

_____

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

HR-BEN-069

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.

_____

_____

_____

_____

_____

_____

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

HR-BEN-069

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

Section V – Agency Contact
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.

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
☐	**LI Bus** MTA LI Bus Medical Unit 700 Commercial Avenue Garden City, NY 11530
☐	**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