Request for Family and Medical Leave Form

HR-BEN-028

Section 1 - Information and Instructions

The Purpose of this form is to request Family and Medical Act Leave (FMLA).

Please fax a signed copy of the form to 212-852-8700 or e-mail a signed copy of the form to bscservices@mtabsc.org.

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

Eligible employees requesting Family and Medical Leave may request a copy of the policy, application and medical certification from their manager, from the BSC Customer Management Center by calling 646-376-0123, or the forms can be downloaded from the BSC Portal. In Non- Emergency situations, employees must request FMLA leave 30 days prior to the start of leave.

When leave is needed to care for a seriously ill family member, proof of the family relationship must be supplied with the FMLA application (i.e. a copy of birth certificate, legal adoption papers, or marriage license, etc.). Employees are required to forward a completed Certification of Health Care Provider in a sealed envelope marked "Confidential- Medical Certification" to their agency's FMLA Medical Department (see attached FMLA Agency Medical Department Checklist for address).

The Medical Certification and proof of relationship must be furnished within 15 days of submitting an FMLA leave request. The failure to do so may result in denial of delay the request.

Employees requesting FMLA leave on an intermittent basis or a reduced leave schedule, must state in the FMLA leave request form why intermittent FMLA is medically necessary, indicating how long the intermittent leave is expected to last, and providing a schedule of proposed dates that the leave will be taken. If intermittent leave is approved, the employee is responsible for keeping their supervisor and the FMLA Administrator informed of their schedule and must schedule medical appointments for themselves or eligible family member, or service member, whenever possible, outside of working hours. The information must be furnished within 15 days of submitting an FMLA leave Request. The failure to do so may result in denial or delay the request.

Request for Military Family Leave under: (1) Qualified exigency must be supported with the service member's active duty orders and certification, or acceptable documentation. (2) Request to care for service member with a serious injury or illness must be supported by a certification completed by health care provider or by a copy of an Invitational Travel Order (ITO) or Invitational Travel Authorization (ITA) issued to any member of the covered service member's family.

Employees returning to work following their own serious medical condition must submit medical clearance from their physician to their Agency Medical Department prior to returning to work. Employees out on unpaid FMLA leave for more than 15 days in one month will not accrue leave time for that month. Unpaid absences do not count toward credited pension service.

Section 2 - Employee Information

Print Name	Last		First		M / Suffix	BSC Employee ID
Agency (check one)	☐ BSC	☐ B&T	☐ CC	☐ HQ	☐ LI Bus	Department
	☐ LIRR	☐ MNR	☐ MTA Bus	☐ NYCT	☐ Police	
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, and to care for, my newborn child. ☐
- The placement with me of a child for adoption or foster care, and to care for the child. ☐
- To care for my spouse, child, or parent with a serious health condition. ☐
- Qualified exigency leave for my spouse, child, or parent on active or called to active duty in support of a contingency operations (National Guard or Reserves only). ☐
- To care for my spouse, child, parent, or next of kin of a service member with a serious injury or illness. ☐

Note: *Leave for the birth, adoption, or placement of a child for foster care must be taken in consecutive workweeks.*

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Section 4 – Dates / Time Requested

(Ex. Begin: Jan 1, 2009 – End: Jan. 31, 2009, with a total of 31 days or 4 weeks.)

a.) Leave Beginning on and Leave Ending on b.) Total # of Days or Total # of Weeks

Indicate the type of leave you are requesting ☐ Continuous ☐ Intermittent

(Intermittent Leave is separate blocks of time due to a single serious health condition, while Continuous leave is consecutive blocks of time.)

If Intermittent, state the reason for leave

Is a reduced leave schedule (reduced workweek or reduced workday) requested? ☐ Y ☐ N

Note: A schedule must be provided and include both known (definite) and anticipated (probable) leave to be taken intermittent or on a reduced schedule in response to both items above and the Certification of Health Care Provider form.

Section 5 – Authorization

1. I understand that a second independent medical opinion, at the MTA's expense, may be required. If the first and second opinions differ, the MTA may require, at its expense, the opinion of a third independent health care provider whose opinion shall be final and binding.
2. I understand that a medical recertification may be required once every thirty (30) days from the commencement of my leave. Failure to provide recertification may result in the denial or continuation of the leave.
3. I understand that I am required to contact the Agency Medical / Agency HR Department, in writing at least once every thirty (30) days while on leave to report on my status and intentions with respect to returning to work at the end of my leave. If I plan to return to work before or after the date specified on this form, I must contact the FMLA Administrator / Agency HR Department immediately.
4. I understand that I will be required to provide a fitness-for-duty medical certification to return to work when the leave is caused by my own serious health condition, and that my return to work may be denied until the certification is provided.
5. I understand I may be required to provide a copy of a service member's orders or other documentation issued by the military to support my request for qualified exigency leave and/ or to care for a service member with a serious injury or illness under the Family and Medical Leave Act.
6. I understand that this leave is counted against my Family and Medical Leave Act (FMLA) entitlement of twelve (12) workweeks.
7. I understand that I may be required to substitute accrued (earned but unused) paid leave for part or all of the unpaid FMLA leave entitlement. Such paid leave is counted against my FMLA twelve (12) workweek leave entitlement.
8. If I currently make contributions for my health benefits, I understand that MTA B&T will continue to make these contributions on my behalf while I am on unpaid FMLA leave, and may deduct such payments from my wages upon my return to work. I understand that if I fail to return to work after my leave expires, I may be held liable for payment of such health insurance premiums paid by the MTA B&T during my unpaid FMLA leave.
9. I understand that upon my return to work from my leave, I will be restored either to the same position or to an equivalent position with equivalent pay and benefits.
10. I understand that fraudulently requesting, obtaining and/ or misusing this leave will be cause for disciplinary action.

Employee Signature	SSN Last 4 Digits	Date

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Section 6 – Agency Department Checklist

FMLA Certifications of Healthcare Providers must be sent to your specific agency medical department. Below is a checklist of all of the agency medical department's information and contact numbers. Please check the appropriate box next to your own agency's medical department.

If you submit the form in error to the wrong department, the MTA Business Service Center cannot be held responsible.

Please select only one box next to the appropriate agency.	Agency Name, Address, and Contact Information
☐	**HQ** MTA Medical Department Occupational Health Services 420 Lexington Ave, suite 2201 New York, NY 10017 Attn: Nurse Manager
☐	**LI Bus** MTA LI Bus Medical Unit 700 Commercial Avenue Garden City, NY 11530
☐	**LIRR** HR 93-02 Sutphin Blvd., Jamaica, NY 11435
☐	**MNR** Angela Pitaro, Administrator of Health Services MTA Metro-North Railroad Occupational Health Services Department 420 Lexington Avenue, 22nd Floor New York, NY 10017