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

FMLA Certification for Serious Injury or Illness of Covered Service Member

HR-BEN-072

Section I – Instructions to the Employee or Covered Servicemember

For Completion by the EMPLOYEE and/or the COVERED SERVICEMEMBER for whom the Employee Is Requesting Leave. Please complete Section I before having Section II completed. The FMLA permits an employer to require that an employee submit a timely, complete, and sufficient certification to support a request for FMLA leave due to a serious injury or illness of a covered servicemember. If requested by the employer, your response is required to obtain or retain the benefit of FMLA-protected leave. 29 U.S.C. §§ 2613, 2614(c)(3). Failure to do so may result in a denial of an employee's FMLA request. 29 C.F.R. § 825.310(f). The employer must give an employee at least 15 calendar days to return this form to the employer. If you have any questions, please contact the MTA Business Service Center (BSC) at 646-376-0123 or bscservice@mtabsc.org.

Section II – Instructions to the United States Department of Defense ("DOD") Provider / Healthcare Provider

SECTION II: For Completion by a UNITED STATES DEPARTMENT OF DEFENSE ("DOD") HEALTH CARE PROVIDER or a HEALTH CARE PROVIDER who is either: (1) a United States Department of Veterans Affairs ("VA") health care provider; (2) a DOD TRICARE network authorized private health care provider; or (3) a DOD non-network TRICARE authorized private health care provider

INSTRUCTIONS to the HEALTH CARE PROVIDER: The employee listed below has requested leave under the FMLA to care for a family member who is a member of the Regular Armed Forces, the National Guard, or the Reserves who is undergoing medical treatment, recuperation, or therapy, is otherwise in outpatient status, or is otherwise on the temporary disability retired list for a serious injury or illness. For purposes of FMLA leave, a serious injury or illness is one that was incurred in the line of duty on active duty that may render the servicemember medically unfit to perform the duties of his or her office, grade, rank, or rating.

A complete and sufficient certification to support a request for FMLA leave due to a covered servicemember's serious injury or illness includes written documentation confirming that the covered servicemember's injury or illness was incurred in the line of duty on active duty and that the covered servicemember is undergoing treatment for such injury or illness by a health care provider listed above. 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.

Section I – For completion by the Employee

Part A: Employee Information (This section must be completed first before any of the below sections can be completed by a health care provider.)

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	

Name of Covered ServiceMember (for whom employee is requesting leave to care):	Last	First	M.I	Suffix

Relationship of Employee to Covered Servicemember Requesting Leave to Care:
☐ Spouse ☐ Parent ☐ Son ☐ Daughter ☐ Next of Kin

Part B: COVERED SERVICEMEMBER INFORMATION

(1) Is the Covered Servicemember a Current Member of the Regular Armed Forces, the National Guard or Reserves? ____Yes ____No

If yes, please provide the covered servicemember's military branch, rank and unit currently assigned to:

_____

FMLA Certification for Serious Injury or Illness of Covered Service Member

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Is the covered servicemember assigned to a military medical treatment facility as an outpatient or to a unit established for the purpose of providing command and control of members of the Armed Forces receiving medical care as outpatients (such as a medical hold or warrior transition unit)? ____Yes ____No

If yes, please provide the name of the medical treatment facility or unit: _____

(2) Is the Covered Servicemember on the Temporary Disability Retired List (TDRL)? ____Yes ____No

Part C: CARE TO BE PROVIDED TO THE COVERED SERVICEMEMBER

Describe the Care to Be Provided to the Covered Servicemember and an Estimate of the Leave Needed to Provide the Care:

_____

_____

Section II

For Completion by a United States Department of Defense ("DOD") Health Care Provider or a Health Care Provider who is either: (1) a United States Department of Veterans Affairs ("VA") health care provider; (2) a DOD TRICARE network authorized private health care provider; or (3) a DOD non-network TRICARE authorized private health care provider. If you are unable to make certain of the military-related determinations contained below in Part B, you are permitted to rely upon determinations from an authorized DOD representative (such as a DOD recovery care coordinator). (Please ensure that Section II above has been completed before completing this section.) Please be sure to sign the form on the last page.

Part A: HEALTH CARE PROVIDER INFORMATION

Health Care Provider's Name and Business Address:

_____

Type of Practice/Medical Specialty: _____

Please state whether you are either: (1) a DOD health care provider; (2) a VA health care provider; (3) a DOD TRICARE network authorized private health care provider; or (4) a DOD non-network TRICARE authorized private health care provider: _____

Telephone: ( ) _____ Fax: ( ) _____ Email:_____

PART B: MEDICAL STATUS

(1) Covered Servicemember's medical condition is classified as (Check One of the Appropriate Boxes):

- ☐ **(VSI) Very Seriously Ill/Injured** – Illness/Injury is of such a severity that life is imminently endangered. Family members are requested at bedside immediately. (Please note this is an internal DOD casualty assistance designation used by DOD healthcare providers.)
- ☐ **(SI) Seriously Ill/Injured** – Illness/injury is of such severity that there is cause for immediate concern, but there is no imminent danger to life. Family members are requested at bedside. (Please note this is an internal DOD casualty assistance designation used by DOD healthcare providers.)
- ☐ **OTHER Ill/Injured** – a serious injury or illness that may render the servicemember medically unfit to perform the duties of the member's office, grade, rank, or rating.
- ☐ **NONE OF THE ABOVE** (Note to Employee: If this box is checked, you may still be eligible to take leave to care for a covered family member with a "serious health condition" under § 825.113 of the FMLA. If such leave is requested, you may be required to complete DOL FORM WH-380 or an employer-provided form seeking the same information.)

(2) Was the condition for which the Covered Service member is being treated incurred in line of duty on active duty in the armed forces? ____ Yes ____ No

(3) Approximate date condition commenced: _____

(4) Probable duration of condition and/or need for care: _____

(5) Is the covered servicemember undergoing medical treatment, recuperation, or therapy? ____ Yes ____ No If yes, please describe medical treatment, recuperation or therapy:

_____

PART C: COVERED SERVICEMEMBER'S NEED FOR CARE BY FAMILY MEMBER

(1) Will the covered servicemember need care for a single continuous period of time, including any time for treatment and recovery? ___ Yes ___ No

If yes, estimate the beginning and ending dates for this period of time:_____

(2) Will the covered servicemember require periodic follow-up treatment appointments? ___ Yes ___ No

If yes, estimate the treatment schedule: _____

(3) Is there a medical necessity for the covered servicemember to have periodic care for these follow-up treatment appointments? ___ Yes ___ No

(4) Is there a medical necessity for the covered servicemember to have periodic care for other than scheduled follow-up treatment appointments (e.g., episodic flare-ups of medical condition)? ____Yes ____No. If yes, please estimate the frequency and duration of the periodic care:

_____

_____

_____

_____

_____

_____

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

FMLA Certification for Serious Injury or Illness of Covered Service Member

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Section IV – 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 Constructions** 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