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

HR-BEN-069

Section 1 - Information and Instructions

The purpose of this form is to submit the required documentation for your FMLA request.

NOTE: You can request a leave of absence under the Family and Medical Leave Act ("FMLA") online at My MTA Portal, www.mymta.info. If you are unable to apply online, you must complete the HR-BEN-028 form 30 days prior to the start of your leave or as soon as possible. See the instructions at the top of the form for how to submit it to your agency.

Please complete Section 2 below before giving this form to your medical 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.

If this certification is 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. 29 C.F.R. § 825.313. Your employer must give you at least 15 calendar days to return this form to your employer. 29 C.F.R. § 825.305.

Section 2 – Employee Information

Print Name	Last			First		M	Suffix	BSC ID:
Employer (check one)	☐ BSC	☐ B&T	☐ C&D	☐ HQ	☐ Police	■ MaBSTOA	Department:	
	☐ SIR	☐ LIRR	☐ MNR	☐ MTA Bus	☐ NYCT		Job Title:	
Street Address							Regular Work Schedule	
City						State	Zip Code	
Phone (H)		Phone (W or M))				Email		

Section 3 – Request for Leave

Leave Start Date	Leave End Date

Section 4 – Type of Leave Requested

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. Reduced Schedule is leave that reduces your usual number of working hours per work week or hours per work day, and a Continuous Leave is taken in consecutive blocks of time.)

b) If Intermittent or reduced schedule, state the anticipated frequency and duration:

Frequency: _____Times per ☐ Day ☐ Month ☐ Rolling Days ☐ Week ☐ Year

Duration _____Hours or _____Day(s) per episode

Employee Signature	Date

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Section 5 – For Completion byte HEALTH CARE PROVIDER		
The employee listed above has requested leave under the FMLA to care for your patient. Answer fully and completely all applicable parts below. 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 patient needs leave. Page 3 provides space for additional information, should you need it. **Do not provide information about genetic tests, as defined in 29 C.F.R. § 1635.3(f), genetic services, as defined in 29 C.F.R. § 1635.3(e), or the manifestation of disease or disorder in the employee's family members, 29 C.F.R. § 1635.3(b).** **Please be sure to sign the form on page 3.**		
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:

Was the patient admitted for an overnight stay in a hospital, hospice, or residential medical care facility?

☐ No ☐ Yes If yes, date 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:

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3. Use the information provided in Section 2 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

1. Will the employee be incapacitated for a single continuous period 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:
   Begin date: End Date:

2. 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

4. 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 INFORM ATION: IDENTIFY QUESTION NUMBER(S) RELATED TO YOUR ADDITIONAL ANSWER

Section 6 – 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 7 – Agency Contact	
Check the box for your agency.	**Submit this form to your agency representative listed below.**
☐	**MTA HQ** Occupational Health Services 420 Lexington Avenue, Suite 2201 New York, NY 10170 Attn: Nurse Manager Email: FMLA@MTAHQ.ORG Fax: 212-878-0266
☐	**MTA Bridges and Tunnels** Robert Moses Building Randall's Island New York, NY 10035-5199 Fax: 646-252-7911
☐	**MTA Long Island Rail Road** Human Resources Department 93-02 Sutphin Boulevard Jamaica, NY 11435 Attention: FMLA Administrator Fax: 718-558-6824 Email: fmla@lirr.org
☐	**MTA Metro-North Railroad** FMLA Administrator Human Resources Department 420 Lexington Avenue, 12th Floor New York, NY 10170 Attention: FMLA Administrator Phone: 212-340-2112 Fax: 212-340-2045 Email: mnrfmla@mnr.org
☐	**MTA NYCT / MaBSTOA/ SIRTOA / MTABUS** Occupational Health Services 180 Livingston Street, Room 4023 Brooklyn, NY 11201 Attention: Office of the Medical Director