FMLA Certification of Serious Injury or Illness of Covered Service Family Member

HR-BEN-072

Section 1 - Information and Instructions

The purpose of this form is to provide the **required medical certification** for your Family and Medical Leave Act (FMLA) request.

Department of Buses, MTA Bus, MaBSTOA, and SIRTOA *Represented Employees* on UTS Payroll ONLY: Do **NOT** complete this medical certification form (HR-BEN-072). You **MUST** contact WorkPartners at 1-833-281-5602 ***or*** NYCTAFMLA@WorkPartners.com for instructions on submitting your FMLA medical certification form.

Long Island Railroad (LIRR) Employees: Do **NOT** complete this medical certification form (HR-BEN-072). You **MUST** instead contact WorkPartners at 1-833-325-7004 ***or*** LIRRFMLA@WorkPartners.com for instructions on submitting your FMLA medical certification form.

Metro-North Railroad (MNR) Employees: Do **NOT** complete this medical certification form (HR-BEN-072). You **MUST** instead contact WorkPartners at 1-833-804-0480 ***or*** MNRFMLA@WorkPartners.com for instructions on submitting your FMLA medical certification form.

All Other MTA Agency Employees: It is important to complete **ALL** applicable sections and questions on this form. Submitting an incomplete form *or* a form without the required signatures will delay the review and processing of your FMLA request.

To apply for FMLA, in addition to the submission of this medical certification form, you **MUST** also submit the FMLA Request Form. As applicable, you may be able to request an FMLA leave online via the My MTA Portal at www.mymta.info. If you are unable to submit the FMLA Request Form via the My MTA Portal ***or*** would prefer to alternatively submit a paper FMLA request application, you **MUST** submit the **HR-BEN-028 FMLA Request Form** at least 30 days prior to the start of your requested leave *or* as soon as practicable.

This completed form **MUST** be submitted to the MTA agency FMLA contact listed on page five (5). For questions about FMLA, you **must** reach out to your respective MTA agency FMLA contact detailed on page three (3) of the **HR-BEN-028** FMLA Request Form.

Please complete **Sections 2, 3, 4, and 7 of this form** *before* giving this form to your covered military family member or their medical provider. 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 a serious injury or illness of a covered service member.

If this medical 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 the denial of your FMLA request. 29 C.F.R.§ 825.313. Your employer must give you at least fifteen (15) calendar days to submit this form. 29 C.F.R. § 825.305.

Section 2 - Employee Information

Print Name	Last		First		M.I.	Suffix	BSC ID#	Pass# (NYCTA/MTA Bus)
Agency (Check Only **ONE**)	MTA HQ/BSC ☐	C&D ☐	NYCTA ☐	SIRTOA ☐	Department			
	B&T ☐	MTA Police ☐	MTA Bus ☐	MaBSTOA ☐	Job Title			
Street Address					Regular Work Schedule			
City					State		Zip Code	
Phone (H)		Phone (W)			Email			
Name (first, last, & middle initial) of covered military/service family member for whom you are requesting leave to care for:					Relationship of covered family member to you: ☐ Spouse ☐ Parent ☐ Child ☐ Next-of-kin			
Describe the care you will provide to your family member:								

Section 3 - Requested FMLA Leave Dates

Requested Leave Start Date:	Requested Leave End Date:

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Section 4 - Type of FMLA Leave Requested

A.) An FMLA leave type **MUST** be selected below:

☐ **Intermittent:** This leave consists of separate blocks of time due to a *single* qualifying reason

☐ **Reduced Schedule:** This leave reduces your usual/standard number of working hours per work week *or* work hours per workday

☐ **Continuous:** This leave is taken in one consecutive block of time with no breaks/gaps

B.) If an **Intermittent** or **Reduced Schedule** leave is selected above, the anticipated frequency and duration **MUST** be indicated below. Failure to provide this information *will result in your FMLA request being delayed or not processed*.

Frequency: _____ times per ☐ Day ☐ Week ☐ Month ☐ Year ☐ Rolling Days

Duration: _____ hours **OR** _____ day(s) per episode

Other Anticipated Frequency & Duration Schedule (**MUST** be specific): _____

Employee Signature:	Date:

PART B: COVERED SERVICE MEMBER INFORMATION

1. Is the covered service member a current member of the regular Armed Forces, the National Guard, or the Reserves?

☐ **NO**

☐ **YES:** If yes, please provide the required information indicated below

Most current assigned military branch, rank, and unit for covered service member: _____

2. Is the covered service member 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 (e.g., a medical hold or warrior transition unit)?

☐ **NO**

☐ **YES:** If yes, please provide the required information indicated below

Name of the medical treatment facility or unit: _____

3. Is the covered service member on the Temporary Disability Retired List (TDRL)?

☐ **NO**

☐ **YES**

PART C: CARE TO BE PROVIDED TO THE COVERED SERVICE MEMBER

Describe the care to be provided to the covered service member. Please also provide an estimate of the leave length and leave type that will be needed to provide this care:

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Section 5 - Instructions to the United States Department of Defense ("DOD") Provider/Health Care Provider

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 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 service member 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 service member's serious injury or illness includes written documentation confirming that the covered service member's injury or illness was incurred in the line of duty on active duty and that the covered service member is undergoing treatment for such injury or illness by a health care provider listed below. Please 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 employee is seeking leave. **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).**

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 2 above has been completed before completing this section.) **Please be sure to sign the form on page 4.**

PART A: HEALTH CARE PROVIDER INFORMATION

Name	Business Address:	
Type of Practice/Medical Specialty:	Are you a: ☐ DOD health care provider ☐ VA health care provider ☐ DOD TRICARE network authorized private health care provider ☐ DOD non-network TRICARE authorized private health care provider	
Telephone	Fax	Email

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PART B: MEDICAL STATUS

1. Covered Service Member's medical condition is classified as:

☐ **Very Seriously Ill/Injured (VSI)** – 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.)

☐ **Seriously Ill/Injured (SI)** – 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 Illness/Injury** – a serious injury or illness that may render the service member medically unfit to perform the duties of the member's office, grade, rank or rating.

☐ **NONE OF THE ABOVE** (If this box is checked, employee 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?
☐ No ☐ Yes If yes, approximate date condition commenced:

3. Probable duration of condition and/or need for care: From To:

4. Is the covered Service Member undergoing medical treatment, recuperation, or therapy?
☐ No ☐ Yes If yes, please describe medical treatment, recuperation or therapy:

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

1. Will the covered Service Member need care for a single continuous period of time, including any time for treatment and recovery?
☐ No ☐ Yes
If yes, estimate the beginning and ending dates for this period: Begin date: End date:

2. Will the covered Service Member require periodic follow-up treatment appointments?
☐ No ☐ Yes If yes, estimate the treatment schedule:

3. Is there a medical necessity for periodic care for these follow-up treatment appointments? ☐ No ☐ Yes

4. Is there a medical necessity for the covered Service Member to have periodic care for other than scheduled follow-up treatment appointments (e.g., episodic flare-ups of medical condition)?
☐ No ☐ Yes. If yes, please estimate the frequency and duration of the periodic care:

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

Duration: Hours or Day(s) per episode

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.

Signature	Date

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Section 7 - Instructions for Submitting Medical Certification Form (HR-BEN-072)

This medical certification form **MUST** be submitted as detailed below to ensure your FMLA request is reviewed and processed in a timely manner.

Please check/select the appropriate box next to your respective MTA Agency and submit this medical certification form as indicated for your agency.

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Select the *correct* box for your specific MTA Agency below	MTA Agency Name & Medical Certification Form Submission Information
☐	**MTA Headquarters (MTA HQ) & MTA HQ Matrixed/MTA Police/MTA Business Service Center (BSC-TCU, BSC-IT, & BSC-Procurement)/MTA Construction & Development (MTA C&D)/MTA Inspector General (MTA IG) Employees** FMLA medical certification forms **MUST** be submitted **DIRECTLY** via email, fax, *or* postal mail to: ○ **Email Address:** FMLA@MTAHQ.org ○ **Fax:** 212-656-1368 ○ **Mailing Address:** Occupational Health Services 420 Lexington Avenue, Suite 2201 New York, NY 10170 Attention: Nurse Manager
☐	**All NYCTA, Department of Buses, MTA Bus, MaBSTOA/SIRTOA *Represented and Non-Represented Employees*** General questions regarding FMLA *medical certification forms* **MUST** be sent to ComplianceAndSupport@NYCT.com. FMLA medical certification forms **MUST** be submitted **DIRECTLY** via email, e-fax, *or* postal mail to: ○ **Email Address:** ComplianceAndSupport@NYCT.com ○ **E-Fax:** 718-744-2671 ○ **Mailing Address:** New York City Transit FMLA-PFL-STD 8th Floor, Room 8.200.43 300 Cadman Plaza West Brooklyn, NY 11201
☐	**MTA Bridges & Tunnels (MTA B&T) Employees** FMLA medical certification forms **MUST** be submitted **DIRECTLY** via email *or* e-fax to: ○ **Email Address:** MTABT-HRLA@mtabt.org ○ **E-Fax:** 646-252-7911