FMLA Certification for Serious Injury or Illness of Covered Service Member

HR-BEN-072

Section 1 - Instructions to the Employee or Covered Service Member

NOTE: **The purpose of this form is to submit the required documentation for your FMLA request.** 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, email or fax a signed copy of the HR-BEN-028 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 should submit completed forms to the BSC at fax# 212-852-8700 or bscservice@mtabsc.org).

For Completion by the EMPLOYEE and/or the COVERED SERVICE MEMBER for whom the Employee Is Requesting Leave.

Please complete Section 2 before having Section 3 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 service member. If this certification is 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 2 - Employee Information

Part A: Employee Information

This section must be completed before any of the following sections can be completed by a health care provider.

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

Name of Covered Service Member (who employee is requesting leave to care for):

Last First M.I Suffix

Relationship of Employee to Covered Service member requesting leave to care for:

☐ Spouse ☐ Parent ☐ Son ☐ Daughter ☐ Next of Kin

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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

Section 5 - Authorization

I am hereby making a request for paid family leave under the MTA Paid Family Leave Policy. *My signature affirms that the information I am providing is true and accurate to the best of my knowledge and belief.*

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 Reserves?
   ☐ No ☐ Yes
   If yes, please provide the currently assigned military branch, rank and unit:

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 (such as a medical hold or warrior transition unit)?
   ☐ No ☐ Yes
   If yes, please provide the name of the medical treatment facility or unit:

2. Is the Covered Service member on the Temporary Disability Retired List (TDRL)?
   ☐ No ☐ Yes

Part C: CARE TO BE PROVIDED TO THE SERVICE MEMBER

Describe the care to be provided and an estimate of the leave needed to provide the care:

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Section 6 - 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 7 - 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 8 – Agency Contact	
Check the box for your agency.	**Submit this form to the 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: 212-6561368
☐	**MTA Bridges and Tunnels** Robert Moses Building Randall's Island New York, NY 10035 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/MTA BUS** New York City Transit FMLA-PFL-STD Floor 8th, Rm 8000.43 300 Cadman Plaza West Brooklyn, NY 11201 E-Fax: 718-744-2671 Email: Complianceandsupport@nyct.com