FMLA Certification of Healthcare Provider for Employee's Serious Health Condition

HR-BEN-069

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. You **MUST** contact WorkPartners at 1-833-281-5602 ***or*** NYCTAFMLA@WorkPartners.com for instructions.

Long Island Railroad (LIRR) Employees: Do **NOT** complete this medical certification form (HR-BEN-069). 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-069). 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 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.

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 ☐	Regular Work Schedule			Department
	B&T ☐	MTA Police ☐	MTA Bus ☐	MaBSTOA ☐	Job Title			
Street Address								
City				State			Zip Code	
Phone (H)		Phone (W)			Email			

Section 3 - Requested FMLA Leave Dates

Requested Leave Start Date:	Requested Leave End Date:

Section 4 - Type of FMLA Leave Requested

An FMLA leave type **MUST** be selected below. Failure to provide this information will result in your FMLA request being delayed or not processed.

☐ **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

Employee Signature:	Date:

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Section 5 – For Completion by HEALTH CARE PROVIDER

The employee listed above has requested leave under the FMLA for their own serious health condition.

- Please answer fully and completely all applicable parts below.
- Your answers regarding frequency and duration of a condition, treatment, etc. 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.
- The last page 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).

Provider, please note, according to CFR Title 5, Chapter 1, Subchapter B, Part 630, Subpart L, a serious health condition does **not** include routine physical, eye, or dental examinations; a regimen of continuing treatment that includes the taking of over-the-counter medications, bed-rest, exercise, and other similar activities that can be initiated without a visit to the health care provider.

Please be sure to sign and date the form.

Provider's Name	License #	State
Type of Practice/Medical Specialty		
Provider's Address		
City	State	Zip Code
Telephone	Fax	
Provider's Email		

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PART A: MEDICAL FACTS (COMPLETE ALL QUESTIONS)

Your answers should be your best estimate. **Be as specific as you can**; terms such as "lifetime," "unknown," or "indeterminate" **may not be sufficient** to determine FMLA coverage.

1. Approximate date the condition started, or will start:

2. Your **best estimate** of how long the condition lasted or will last:

3. Was the patient admitted for an overnight stay in a hospital, hospice, or residential medical care facility? ☐ No ☐ Yes
   If yes, date of admission:

4. Date(s) you treated the patient for condition:

5. Will the patient need to have *treatment visits at least twice per year **due to the condition**.
   ☐ No ☐ Yes

*Treatment visit: A medical appointment that results in a regimen of continuing treatment under the supervision of the health care provider. For example, the provider might perform a treatment in the facility, prescribe a course of prescription medication, or recommend therapy requiring special equipment.

6. Was medication, other than over-the-counter medication, prescribed?
   ☐ No ☐ Yes

7. 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:

8. Is the medical condition pregnancy?
   ☐ No ☐ Yes If so, expected delivery date:

9. 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 their job functions.

   Is the employee unable to perform any of their job functions due to the condition:
   ☐ No ☐ Yes
   If so, identify the job functions the employee is unable to perform:

10. If needed, describe other appropriate medical facts related to the condition(s) for which the employee seeks FMLA leave. (e.g., use of nebulizer, dialysis).

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PART B: AMOUNT OF LEAVE NEEDED – Complete ONLY the following section that applies:

11. For Continuous Leave; 12. For Reduced Work Schedule; 13. For Intermittent Leave

11. Will the employee be incapacitated for a **single continuous** period due to the serious health condition?

☐ No ☐ Yes

If so, estimate the start and end dates for the period of incapacity:

Start date: _____ End date: _____

12. Due to the serious health condition, is it medically necessary for the employee to work a predictable **reduced weekly work schedule**?

☐ No ☐ Yes

If the answer is "yes," **explain** why a reduced work schedule is medically necessary:

_____

If the answer is "yes," provide a recommended **reduced work schedule.**

Recommended days to work (e.g. M, T, W, Th...): _____

Recommended hours to work (e.g. 8 hrs/day...): _____

Time period during which a reduced schedule will be needed:

Start date: _____ End date: _____

13. Due to the serious health condition, is it medically necessary for the employee to be absent from work **intermittently**?

☐ No ☐ Yes

If the answer is "yes," **explain** why it is medically necessary for the employee to be absent from work intermittently for the below frequency and duration:

_____

Based upon the patient's medical history and your knowledge of the medical condition, estimate the frequency of medically necessary **intermittent work** absences during the indicated period of time (e.g., Frequency 1 time per 3 months; Duration 1-2 days per episode; From Jan 1 - June 30):

Frequency: _____ time(s) each week _____ time(s) each month _____ time(s) each year

Duration per episode (e.g., 2 days): _____

Start date of intermittent leave: _____ *End date of intermittent leave: _____

***If the end date is currently unknown, subject to change, or greater than 6 months, please provide the date of the next re-evaluation.**

ADDITIONAL INFORMATION (IDENTIFY THE ASSOCIATED QUESTION NUMBER(S)):

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-069)

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