FMLA Certification of Health Care Provider Family Member's Serious Health Condition

HR-BEN-070

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 2-4 before giving this form to your family member or his/her 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 to care for a covered family member with a serious health condition. 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. If you have any questions regarding the above, please contact your agency Human Resources Department.

If you have any questions, please contact the Business Service Center (BSC) at 646-376-0123 or bscservice@mtabsc.org.

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				
Name of Family Member for whom you will provide care:				Relationship of family member to you ☐ Parent ☐ Spouse ☐ Child If son or daughter, date of birth:				

Describe the care you will provide to your family member:

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 - To be completed by the HEALTH CARE PROVIDER

The employee listed above has requested leave under the FMLA to care for your patient. 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 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 4.

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 so, dates of admission:

   Date(s) you treated the patient for condition:

   Was medication, other than over-the-counter medication, prescribed?

   ☐ No ☐ Yes

   Will the patient need to have treatment visits at least twice per year due to the condition?

   ☐ 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:

3. Describe other relevant medical facts, if any, related to the condition for which the patient needs care (such medical facts may include symptoms, diagnosis, or any regimen of continuing treatment such as the use of specialized equipment):

PART B: AMOUNT OF CARE NEEDED:

When answering these questions, keep in mind that your patient's need for care by the employee seeking leave may include assistance with basic medical, hygienic, nutritional, safety or transportation needs, or the provision of physical or psychological care:

1. Will the patient be incapacitated for a single continuous period of time, 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:

During this time, will the patient need care?

☐ No ☐ Yes

If so, explain the care needed by the patient and why such care is medically necessary:

2. Will the patient require follow-up treatments, including any time for recovery?

☐ 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:

Explain the care needed by the patient, and why such care is medically necessary:

3. Will the patient require care on an intermittent or reduced schedule basis, including any time for recovery?

☐ No ☐ Yes If so, estimate the hours the patient needs care on an intermittent basis, if any:

Hour(s) per day; days per week from through

Explain the care needed by the patient, and why such care is medically necessary:

4. Will the condition cause episodic flare-ups periodically preventing the patient from participating in normal daily activities?

☐ No ☐ Yes

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) day(s)

Duration: Hours or per episode

Does the patient need care during these flare-ups?

☐ No ☐ Yes

Explain the care needed by the patient, and why such care is medically necessary:

ADDITIONAL INFORMATION: IDENTIFY QUESTION NUMBER(S) WITH 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.

Signature	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: 212-656-1368
☐	**MTA Bridges and Tunnels** Human Resources Department 1 Robert Moses Building Randall's Island, NY 10035 Attn: Leave Administration Fax: 646-252-7911 Phone: 212-360-2946/2950
☐	**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