EMPLOYEE'S OWN HEALTH CONDITION

Employee's FMLA Employee Guidelines

Employee's FMLA Rights and Responsibility

Departmental - FMLA Supplemental Information Form

Employee Completes and submits to FMLA Unit
If FMLA is needed within less 30 days employee must submit proof of need

HR BEN 028 – FMLA Application

Employee Completes and submits to FMLA Unit

- Agency ID is the same as Pass Number
- Reg Work Sched: List Days & Time or Tour (PM, AM, Midnight)
- Request Dates: 30 days from the date application is signed, if FMLA is needed sooner, consult with FMLA Leave Representative

HR Ben 069 – Medical Certification

Write Pass Number on top of first page
Employee completes Section I
FMLA Unit Completes Section II
Employee's Physician completes Section III

MTA New York City Transit Authority
Operations Support – Employee Availability-SUBWAYS
Family Medical Leave (FMLA) – Employee Guidelines-OHC

FMLA eligibility is based on the following criteria:

- One full year & minimum of 1250 actual work hours preceding actual request date
- Additionally, if it is a renewal application, you must have available FMLA days

FMLA Leave Time is entitlement as follows:

- FMLA Leave can be requested as Intermitted or Continuous
- FMLA Leave provides up to 60 Work Days or 12 Weeks Continuously in a rolling year
- FMLA Military Leave (Health) provides up to 26 Weeks in a single 12 month period
- FMLA Qualifying Military Exigency provides up to 12 weeks.

After Submitting an FMLA Request Application:

1. You will receive a letter from the MTA Business Service Center (BSC) concerning your eligibility (either you are eligible or you are not eligible) status with 5-7 days of submission.
2. You will receive an "Approval" or Disapproval letter from the BSC after your Medical Certification is reviewed by the Medical Department (OHS) within 30 days.
3. You may begin your FMLA leave on the date you specified on your application if you have received an Approval letter. If you **have not received an approval letter** and your request date to begin is approaching within 5 days call (718) 694-3070 to inquire.

Call Out Procedures – Always make Two (2) Calls to ensure FMLA absence

- **Call your crew reporting center (OSAC or CREW office), Time/Car Desk, Control Desk or Office Manager/Supervisor (aka follow your normal call out procedures)**
  - You must state you are calling out FMLA
    - **For Family Member** – state mother, father, spouse, daughter, son
    - ***For Yourself*** *– FMLA-Sick (RTO-state symptom or body part (aka headache or head)*

THEN YOU ARE REQUIRED TO CALL

- **2. Call the FMLA Desk (718) 694-3070**
  - State your Name, Pass #, Title, RDOs
  - State the complete date you are taking FMLA (Month, day and year)
  - State whom the FMLA is for (child, spouse, parent, yourself)
  - State which type of leave you are requesting (AVA, VAC Days, PLD, OTO)

Leave Usage

- **FMLA For Family Member**
  - You must use any leave balance other than sick
  - Your request must be in writing, print your name, pass # and sign then faxed request the same day to (718) 694-5363 for 5 days and over (Use LOA form).
  - You must state the days of the request and what type of leave you want to apply on a G2, for example: Monday, March 11, 2013 Apply one (1) AVA
  - When you have requested to break up a week's vacation, you must state the vacation week #.
- **FMLA for Your Own Health Condition**
  - Sick Leave Balances are applied first to all FMLA request
  - After Sick leave is exhausted
    - you can request Sick without Pay
    - you can request Vacation/AVA/OTO in lieu of sick

Employee's Responsibility

- **All MTA NYCT Sick Rules Apply – Submitting SICK FORMS & Dr. Lines**
- **The top portion of your Sick Form should state FMLA with a symptom**
- **If you are required to submit Dr. Lines, Your Physician can list a Diagnosis Code**
  - **A Copy of your sick form must be submitted to FMLA**

MTA New York City Transit
Manhattan & Bronx Surface Transit Operating Authority

SAMPLE

TO BE PREPARED IN DUPLICATE

Application for Leave of Absence Due to Illness

DEPARTMENT _____ RC#/DIVISION _____ Date _____ 20 _____

Name _____ Title _____ RDO _____ Pass No. _____

Absent from _____, 20 _____, _____ A.M. P.M. to _____, 20 _____, _____ A.M. P.M. inclusive working for a total of _____ days.

I was unfit for work on account of illness during this period and request a paid/unpaid (circle as appropriate) leave of absence because (state nature of disability):

FMLA
(state a symptom)

Did this disability arise as a result of a service connected incident? _____ Yes/No

Name of treating physician _____ (print) Address _____ (print) Telephone No. _____

_____ Employee's Signature Received: _____ Supervisor Pass No. _____ Date _____

Failure to submit this application within three (3) days after returning to work will result in loss of pay for the period in question and may also result in disciplinary action against the employee. Where absence is for more than two (2) days, this certification must be completely filled out by the attending physician before sick leave with pay will be approved. OA employees should be guided by the applicable section of the collective bargaining agreement to determine when a physician's certification is required.

DOCTOR'S CERTIFICATION

I hereby certify that _____ (Employee's Name) was treated by me on the date/s and for illness noted below:

Dates of treatment: Home _____ Office _____ Hospital _____

DIAGNOSIS/OBJECTIVE FINDINGS

Diagnosis Code

TREATMENT/PROGNOSIS AND EXPECTED DATE OF RETURN

I further certify that this illness so incapacitated this employee that he/she was incapable of performing his/her duties during the period from: _____ to _____, and that the information in this section, which will be used for payment purposes, is truthful.

Physician Stamp

Date _____

_____
Physician's Signature/Tax ID No.

TO BE PREPARED IN DUPLICATE — DEPARTMENT MUST COMPLETE REVERSE SIDE

68-60-0329 8/00

EMPLOYEE RIGHTS AND RESPONSIBILITIES UNDER THE FAMILY AND MEDICAL LEAVE ACT

Basic Leave Entitlement

FMLA requires covered employers to provide up to 12 weeks of unpaid, job-protected leave to eligible employees for the following reasons:

- for incapacity due to pregnancy, prenatal medical care or child birth;
- to care for the employee's child after birth, or placement for adoption or foster care;
- to care for the employee's spouse, son, daughter or parent, who has a serious health condition; or
- for a serious health condition that makes the employee unable to perform the employee's job.

Military Family Leave Entitlements

Eligible employees whose spouse, son, daughter or parent is on covered active duty or call to covered active duty status may use their 12-week leave entitlement to address certain qualifying exigencies. Qualifying exigencies may include attending certain military events, arranging for alternative childcare, addressing certain financial and legal arrangements, attending certain counseling sessions, and attending post-deployment reintegration briefings.

FMLA also includes a special leave entitlement that permits eligible employees to take up to 26 weeks of leave to care for a covered service-member during a single 12-month period. A covered servicemember is: (1) a current member of the Armed Forces, including a member of the National Guard or 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*; or (2) a veteran who was discharged or released under conditions other than dishonorable at any time during the five-year period prior to the first date the eligible employee takes FMLA leave to care for the covered veteran, and who is undergoing medical treatment, recuperation, or therapy for a serious injury or illness.*

***The FMLA definitions of "serious injury or illness" for current servicemembers and veterans are distinct from the FMLA definition of "serious health condition".**

Benefits and Protections

During FMLA leave, the employer must maintain the employee's health coverage under any "group health plan" on the same terms as if the employee had continued to work. Upon return from FMLA leave, most employees must be restored to their original or equivalent positions with equivalent pay, benefits, and other employment terms.

Use of FMLA leave cannot result in the loss of any employment benefit that accrued prior to the start of an employee's leave.

Eligibility Requirements

Employees are eligible if they have worked for a covered employer for at least 12 months, have 1,250 hours of service in the previous 12 months*, and if at least 50 employees are employed by the employer within 75 miles.

***Special hours of service eligibility requirements apply to airline flight crew employees.**

Definition of Serious Health Condition

A serious health condition is an illness, injury, impairment, or physical or mental condition that involves either an overnight stay in a medical care facility, or continuing treatment by a health care provider for a condition that either prevents the employee from performing the functions of the employee's job, or prevents the qualified family member from participating in school or other daily activities.

Subject to certain conditions, the continuing treatment requirement may be met by a period of incapacity of more than 3 consecutive calendar days combined with at least two visits to a health care provider or one visit and a regimen of continuing treatment, or incapacity due to pregnancy, or incapacity due to a chronic condition. Other conditions may meet the definition of continuing treatment.

Use of Leave

An employee does not need to use this leave entitlement in one block. Leave can be taken intermittently or on a reduced leave schedule when medically necessary. Employees must make reasonable efforts to schedule leave for planned medical treatment so as not to unduly disrupt the employer's operations. Leave due to qualifying exigencies may also be taken on an intermittent basis.

Substitution of Paid Leave for Unpaid Leave

Employees may choose or employers may require use of accrued paid leave while taking FMLA leave. In order to use paid leave for FMLA leave, employees must comply with the employer's normal paid leave policies.

Employee Responsibilities

Employees must provide 30 days advance notice of the need to take FMLA leave when the need is foreseeable. When 30 days notice is not possible, the employee must provide notice as soon as practicable and generally must comply with an employer's normal call-in procedures.

Employees must provide sufficient information for the employer to determine if the leave may qualify for FMLA protection and the anticipated timing and duration of the leave. Sufficient information may include that the employee is unable to perform job functions, the family member is unable to perform daily activities, the need for hospitalization or continuing treatment by a health care provider, or circumstances supporting the need for military family leave. Employees also must inform the employer if the requested leave is for a reason for which FMLA leave was previously taken or certified. Employees also may be required to provide a certification and periodic recertification supporting the need for leave.

Employer Responsibilities

Covered employers must inform employees requesting leave whether they are eligible under FMLA. If they are, the notice must specify any additional information required as well as the employees' rights and responsibilities. If they are not eligible, the employer must provide a reason for the ineligibility.

Covered employers must inform employees if leave will be designated as FMLA-protected and the amount of leave counted against the employee's leave entitlement. If the employer determines that the leave is not FMLA-protected, the employer must notify the employee.

Unlawful Acts by Employers

FMLA makes it unlawful for any employer to:

- interfere with, restrain, or deny the exercise of any right provided under FMLA; and
- discharge or discriminate against any person for opposing any practice made unlawful by FMLA or for involvement in any proceeding under or relating to FMLA.

Enforcement

An employee may file a complaint with the U.S. Department of Labor or may bring a private lawsuit against an employer.

FMLA does not affect any Federal or State law prohibiting discrimination, or supersede any State or local law or collective bargaining agreement which provides greater family or medical leave rights.

FMLA section 109 (29 U.S.C. § 2619) requires FMLA covered employers to post the text of this notice. Regulation 29 C.F.R. § 825.300(a) may require additional disclosures.

New York City Transit
Department of Subways/Division of Operations Support
Employee Availability FMLA Supplemental Information

CONTACT INFORMATION:
130 Livingston Street, 6th Floor
(718) 694-3070 (FMLA Desk)
(718) 694-5363 (Fax)
(646) 252-6505 (E-fax)
SubwaysFMLA@nyct.com (Email)

EMPLOYEE INFORMATION			
Today's Date:	**Last Name:**		**First:**
Pass No.	**BSC ID:**		**Hire Date/Year:**
Is this your first FMLA Application?	YES ☐ NO ☐		**If no, year of last application?**
Do you need FMLA in less than 30 days?	YES ☐ NO ☐		**If yes, reason & date:** *(example: Surgery, Hospitalization, etc.)*

JOB INFORMATION		
Title:	**Department:**	**RC #:**
Work Hours/Days:	**Work Location:**	**RDO:**
Timekeepers Name (ONLY for MOW, DCE & Administrative Employees):	**Manager's/Supervisors Name (ONLY for MOW, DCE & Administrative Employees):**	

DOCUMENTATION REQUIRED FOR LEAVE – THIS SECTION FOR FAMILY MEMBER ONLY

If the reason for FMLA is for **other than yourself**, **you must provide proof of relationship**; this may include but not limited to marriage license, court documents for adoption, foster care, guardianships, birth certificates, affidavit, military: active duty orders, or as deemed appropriate.

Care for Spouse ☐ **Care for Child** ☐ **Care for Parent** ☐ **Military** ☐ **Birth of Child** ☐ **Foster Care or Adoption** ☐

Family Member Name:	**Child over 18** YES ☐ NO ☐
Family Member's Residence – City, State, County and/or Country:	
If you are traveling out of State or the Country, please indicate dates, place and provide copy of travel documents:	***Only FMLA Liaison note type of travel document accepted:***
Proof of Relationship Document submitted: (ONLY *FMLA Representative to write in this Section*)	

EMERGENCY CONTACT	
Name:	**Relationship:**
Primary Phone:	**Cell Phone:**

DISCLAIMER AND SIGNATURE

I certify that my answers are true and complete to the best of my knowledge. I understand that false or misleading information in my application may result in the denial of FMLA. I further understand that processing of my application cannot occur if required proof of relationship documents is not submitted with my FMLA application, unless otherwise waived for 3-5 days, due to emergency status. If waiver is granted and proof is not submitted, I understand that my FMLA may be denied and time allowed may be revoked.

Signature:		**Date:**

FMLA REPRESENTATIVE RECEIPT OF APPLICATION & DOCUMENTATION

Print Name: _____ Signature _____ Date _____

Family and Medical Leave Act Application Form

HR-BEN-028

Section 1 - Information and Instructions

The purpose of this form is to request a leave of absence under the Family and Medical Leave Act ("FMLA").

Please mail or fax a signed copy of the completed form to your Agency Human Resources Department or FMLA Coordinator 30 days prior to the start of your leave or as soon as possible. (MTAHQ and BSC Employees must forward completed forms to the BSC at fax#: 212-852-8700 or bscservice@mtabsc.org)

If your request for FMLA is for your own or a family member with a serious health condition, a medical certification is required. Therefore, please visit the BSC Portal (www.mtabsc.info) to download the applicable FMLA application and medical certification listed below:

a) HR-BEN-069 FMLA Certification of Health Care Provider Employee's Serious Health Condition

b) HR-BEN-070 FMLA Certification of Health Care Provider Family Serious Health Conditions

c) HR-BEN-071 FMLA Certification of Qualifying Exigency for Military Family Leave

d) HR-BEN-072 FMLA Certification for Serious Injury or Illness of Covered Service Member

Eligible employees requesting a leave under the FMLA may request a copy of the applicable policy, and the application and Certification of Healthcare Provider form from their manager or the MTA Business Service Center by calling 646-376-0123. The policies and forms can be downloaded from the BSC Portal (www.mtabsc.info). An employee must request FMLA leave 30 days prior to the start of the leave, unless such notice is not practicable, in which case, the employee must provide notice as soon as possible.

The FMLA provides eligible employees with up to 12 weeks of unpaid leave for the following reasons: (1) incapacity due to pregnancy, prenatal medical care or childbirth; (2) to care for a child after birth, or placement for adoption or foster care; (3) to care for a spouse, child, or parent who has a serious health condition; (4) for the employee's own serious health condition that makes them unable to perform their job; and (5) to address certain qualifying exigencies if a spouse, child or parent is on active duty or called to active duty in a foreign country. The FMLA also provides up to 26 weeks of leave to care for a covered service member who has a serious illness or injury under certain circumstances.

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

Section 2 - Employee Information

Print Name	Last		First		M.I. Suffix	BSC ID / Agency ID
Agency/Dept (check one)	☐ BSC	☐ B&T	☐ CC	☐ HQ	☐ Police	Department
	☐ SIR	☐ LIRR	☐ MNR	☐ MTA Bus	☐ NYCT	Job Title
					☐ MaBSTOA	Reg Work Sched
Street Address						
City					State	Zip Code
Phone (H)			Phone (W)			Email

Section 3 – Reason For Leave

Please Check only one:	
My own serious health condition renders me unable to perform the functions of my position.	☐
The birth of a child, or to care for a child within 12 months of date of birth.	☐
The placement with me of a child for adoption or foster care, or to care for a child	☐
To care for my ☐ spouse, ☐ child, or ☐ parent with a serious health condition. (Child's DOB:).	☐
Qualified exigency leave for my ☐ spouse, ☐ child, or ☐ parent on active duty or called to active duty in a foreign county	☐
To care for my ☐ spouse, ☐ child, ☐parent, or ☐ next of kin who is a covered service member with a serious injury or illness	☐

Family and Medical Leave Act Application Form

HR-BEN-028

Section 4 – Request for Leave	
Leave beginning on	and leave ending on
Total number of work days	or total number of work weeks

Section 5 – 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. A reduced schedule leave is a leave schedule that reduces your usual number of working hours per workweek or hours per work day, and a continuous leave is taken in consecutive blocks of time.)

b) If Intermittent, or reduced schedule leave, state the schedule you are requesting:

Section 6 - Authorization

I do hereby certify that to the best of my knowledge the above information is true and correct.

I understand that fraudulently requesting, obtaining and/ or misusing this leave will be cause for disciplinary action, up to and including dismissal from employment.

Employee Signature	Date
Supervisor's Signature	Date

For Agency Human Resources Use Only (check one):

☐ Meets Eligibility Requirements: ☐ Does Not Meet Eligibility Requirements:

Print Name	Signature	Date

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

HR-BEN-069

Section I – For completion by the Employee

INSTRUCTIONS to the EMPLOYEE: Please complete Section I before giving this form to your health care 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 due to your own serious health condition. If 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. 20 C.F.R. § 825.313. Your employer must give you at least 15 calendar days to return this form. 29 C.F.R. § 825.305(b).

Print Name	Last			First		M C	Suffix	BSC ID:
Employer (check one)	☐ BSC	☐ B&T	☐ CC	☐ HQ	☐ Police	☐ MaBSTOA		Department:
	☐ SIR	☐ LIRR	☐ MNR	☐ MTA Bus	☐ NYCTA			
Street Address								
City						State NY		Zip Code
Phone (H)			Phone (W)			Email		

Section II – For completion by the Employer

Employee's Job Title:	Regular Work Schedule:
Employee's Essential Job Functions:	
☐ Check if job description is attached	

Section III – For Completion by the HEALTH CARE PROVIDER

Instructions to the Health Care Provider: Your patient has requested leave under the FMLA. Answer, fully and completely, all applicable parts. 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. **Please be sure to sign the form on the last page.**

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: _____

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

HR-BEN-069

Mark below as applicable:
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:

_____

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: _____

3. Use the information provided by the employer in Section II 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

5. Will the employee be incapacitated for a single continuous period of time 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: _____

6. 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 _____

7. 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 INFORMATION: IDENTIFY QUESTION NUMBER WITH YOUR ADDITIONAL ANSWER.

_____

_____

_____

_____

_____

_____

_____

Section IV – Signature of Health Care Provider	
I do hereby certify that to the best of my knowledge the above information is true and correct.	
	Date

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

HR-BEN-069

Section V – Agency Contact

This Medical Certification form must be sent to your specific Agency representative. Below is a list of all of the Agency contacts. Please check the appropriate box next to your own Agency's contact.

Please select only one box next to the appropriate Agency.	Agency Name, Address, and Contact Information
☐	**MTA & MTA Capital Construction** MTA Medical Department Occupational Health Services 420 Lexington Avenue, Suite 2201 New York, NY 10017 Attn: Nurse Manager
☐	**LIRR** Human Resources Department 93-02 Sutphin Boulevard Jamaica, NY 11435
☐	**Metro-North Railroad** FMLA Administrator Human Resources 347 Madison Avenue, 4th Floor New York, NY 10017
☐	**Staten Island Railroad (SIR)** Human Resources Department 60 Bay Street Staten Island, NY 10301
☐	**NYCT / MaBSTOA / MTA BUS** Occupational Health Services 180 Livingston Street Brooklyn, NY 11201