FMLA Certification for Serious Injury or Illness of Covered Service Member

HR-BEN-072

Section 1 – Instructions for Employee or Covered Service Member

NOTE: Remember to complete and submit an **HR-BEN-028: Family and Medical Leave Act Application Form** to Agency HR or FMLA Coordinator.

For Completion by the EMPLOYEE and/or the COVERED SERVICE MEMBER for whom the Employee Is Requesting Leave. Please complete Section 3 before having Section 4 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 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 – Instructions to the United States Department of Defense ("DOD") Provider / Healthcare 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 network 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 above. 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.

Section 3 – For Completion by the Employee

PART A: Employee Information (This section must be completed first, before any of the below sections can be completed by a health care provider.)

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	Regular Work Schedule:
Street Address						
City					State	Zip Code
Phone (H)		Phone (W)				Email

Name of covered military member on active duty or call to active duty status in support of a contingency operation.

Last First M.I. Suffix

Relationship of family member to you: ☐ Spouse ☐ Parent ☐ Son ☐ Daughter ☐ Next of Kin

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? ☐ Yes ☐ No

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If yes, please provide the covered Service Member's military branch, rank, and unit currently assigned to:

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)? ☐ Yes ☐ No

If yes, please provide the name of the medical treatment facility or unit: _____

(2) Is the Covered Service Member on the Temporary Disability Retire List (TDRL)? ☐Yes ☐No

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

Describe the Care to Be Provided to the Covered Service Member and an Estimate of the Leave Needed to Provide the Care:

Section 4 – For Completion by 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 network authorized private health care provider; or (3) a DOD non-network TRICARE authorized private health care provider. 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 II above has been completed before completing this section.) Please be sure to sign the form on the last page.

Part A: HEALTH CARE PROVIDER INFORMATION

Health Care Provider's Name and Business Address:
Type of Practice/Medical Specialty:

Please state whether you are either: (1) a DOD health care provider; (2) a VA health care provider; (3) a DOD TRICARE network authorized private health care provider; or (4) a DOD non-network TRICARE authorized private health care provider:

Telephone:_____Fax:_____Email:_____

PART B: MEDICAL STATUS

(1) Covered Service Member's medical condition is classified as (Check One of the Appropriate Boxes):

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

☐ **(SI) Seriously Ill/Injured** – 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 Ill/Injured** – 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.

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☐ **NONE OF THE ABOVE** (Note to Employee: If this box is checked, you 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?

☐ Yes ☐ No

(3) Approximate date condition commenced:

(4) Probable duration of condition and/or need for care: _____

(5) Is the covered service member undergoing medical treatment, recuperation, or therapy?

☐ Yes ☐ No. 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?

☐ Yes ☐ No

If yes, estimate the beginning and ending dates for this period of time:_____

(2) Will the covered service member require periodic follow-up treatment appointments? ☐ Yes ☐No

If yes, estimate the treatment schedule: _____

(3) Is there a medical necessity for the covered service member to have periodic care for these follow- up treatment appointments?

☐Yes ☐ No

(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)?

☐ Yes ☐ No. If yes, please estimate the frequency and duration of the periodic care:

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Section 5 – 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

Section 6 – Agency Contact	
This 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
☐	**SIR** Human Resources Department 60 Bay St. Staten Island, NY 10301
☐	**LIRR** Human Resources Department 93-02 Sutphin Boulevard Jamaica, NY 11435
☐	**Metro-North Railroad** Administrator of Health Services MTA Metro-North Railroad Occupational Health Services Department 420 Lexington Avenue, 22nd Floor New York, NY 10017
☐	**NYCT / MaBSTOA / MTA Bus** Occupational Health Services 180 Livingston St. Brooklyn, NY 11201