Family and Medical Leave Act Request 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).

DO NOT COMPLETE THIS FORM IF YOU HAVE APPLIED ONLINE

TO APPLY ONLINE:

1) Sign on to My MTA Portal – www.mymta.info
2) Click the My Benefits Ribbon
3) Click the FMLA Request Link
4) Be sure to click the icons next to the link to access essential information

TO USE THIS FORM:

If you are unable to apply online, complete this form and submit at least 30 days prior to the start of your leave or as soon as possible

- **For NYCT/MTA Bus Employees:** Mail, email, or fax this form to your Agency FMLA Coordinator. Email questions to FMLASupport@nyct.com (DO NOT send this form to this mailbox)
- **For All other MTA Agency Employees:** Mail, email, or fax this form to your Agency Human Resources Department or FMLA Coordinator
- **For MTA HQ and BSC Employees:** Email or fax this form to the MTA BSC at bscservice@mtabsc.org or 212-852-8700

ADDITIONAL DOCUMENTATION IS REQUIRED IF REQUESTING FMLA DUE TO A MEDICAL CONDITON

If your request for FMLA is for you or a family member with a serious health condition, a medical certification is **required**. Visit My MTA Portal, www.mymta.info to download the applicable FMLA application and medical certification:

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 Member's Serious Health Condition

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

EMPLOYEE RIGHTS UNDER THE FAMILY AND MEDICAL LEAVE ACT

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
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
6) 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

The complete Employee Rights document can be downloaded from My MTA Portal, www.mymta.info or obtained from your manager or the MTA Business Service Center at 646-376-0123.

If you have any questions about FMLA leave, please contact your agency Human Resources Department.

Section 2 - Employee Information

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

Family and Medical Leave Act Request Form

HR-BEN-028

Section 3 - Reason for Leave	
Please check only one:	
My own serious health condition or pregnancy renders me unable to perform the functions of my position	
The birth and/or care of a child within 12 months of date of birth (Provide verification of child's 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 ☐ parent with a serious health condition (Provide date of birth of care recipient):	
Qualified exigency leave for my ☐ spouse ☐ child ☐ parent on active duty or called to active duty in a foreign county	
To care for my ☐spouse ☐ child ☐ parent ☐ next of kin who is a covered service member with a serious injury or illness ☐ for my pregnant spouse	

Section 4 - Request for Leave	
Leave Start Date	Leave End Date

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. Reduced schedule leave is a leave schedule that reduces your usual number of working hours per workweek or hours per workday. Continuous leave is taken in consecutive blocks of time.)
b) If intermittent or reduced schedule leave is being requested, state the **specific** 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

Family and Medical Leave Act Request Form

HR-BEN-028

Section 8 – Agency Contact

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

****For COVID-19 Childcare requests submit this form and HR-BEN-929 Childcare documentation form according to the instructions in Section 1. DO NOT submit to the contacts below.**

Check the box for your agency.	Agency Name, Address, and Contact Information *Note: Bridges and Tunnels employees should contact their agency Human Resources Department*
☐	**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** Robert Moses Building Randall's Island New York, NY 10035-5199 Fax: 646-252-7911
☐	**MTA - Long Island Rail Road** Hum an 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 Hum an 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

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

FMLA Certification for Serious Injury or Illness of Covered Service Member

HR-BEN-072

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:

FMLA Certification for Serious Injury or Illness of Covered Service Member

HR-BEN-072

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

FMLA Certification for Serious Injury or Illness of Covered Service Member

HR-BEN-072

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

FMLA Certification for Serious Injury or Illness of Covered Service Member

HR-BEN-072

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

FMLA FAQS

What am I entitled to with FMLA? Eligible employees who work for a covered employer (NYCT is covered), can take up to 12 weeks of unpaid, job protected leave in a 12-month period for the following reasons:

- Birth of a child or placement of a child for adoption or foster care.
- To bond with a child (leave must be taken within 1 year of the child's birth or placement).
- To care for the employee's spouse, child, or parent who has a qualifying serious health condition.
- For the employee's own qualifying serious health condition that makes the employee unable to perform their job.
- For qualifying exigencies related to the foreign deployment of a military member who is the employee's spouse, child, or parent. An eligible employee who is a covered service member's spouse, child, parent or next of kin may also take up to 26 weeks of FMLA leave in a single 12-month period to care for the servicemember with a serious injury or illness.

How do I qualify for FMLA?

- Employee must have worked for MTA-NYCT for a total of at least 12 months.
- Employee must have worked a total of 1250 hours in a year preceding the start of the leave.

What FMLA forms do I need?

- FMLA for yourself (your own illness) – **HR-BEN-028 & HR-BEN-069**
- FMLA for family member (to care for a family member) – **HR-BEN-028 & HR-BEN-070**
- FMLA for Military Exigency Certification – **HR-BEN-028 & HR-BEN-071**
- FMLA for covered service member – **HR-BEN-028 & HR-BEN-072**

Where do I get the FMLA forms?

- BSC Employee self-service website – www.mymta.info
    1. Log in to My MTA Portal
    2. Click on "*Forms and Information*"
    3. Click on "*Human Resources*" folder
    4. Click on "*FMLA*" folder
    5. Choose the forms that apply to you
- FMLA Unit email – SubwaysFMLA@nyct.com
- FMLA Unit at 130 Livingston Street, 6th floor, Brooklyn, NY, 11201

What other documentation do I have to submit along with my application when applying for a family member?

- Employee's must submit proof of relation.
- When applying to care for a child – Submit a copy of the child's birth certificate
- When applying to care for a parent – Submit a copy of your own birth certificate
- When applying to care for a spouse – Submit a copy of your marriage certificate
- When applying for child bonding – If married, submit a copy of your marriage certificate and discharge papers that state the child's date of birth. If not married, submit documentation from the hospital stating the child's date of birth and listing you as the parent. **The birth certificate must be provided once received.**

Where do I send the FMLA forms? Can I submit them electronically?

- **HR-BEN-028, (Military - HR-BEN-071, HR-BEN-072)** forms – Email SubwaysFMLA@nyct.com or mail/bring in person to 130 Livingston, 6th floor, Brooklyn, NY, 11201.
- To submit the **HR-BEN-028** form electronically go to:
    1. BSC Employee self-service website – www.mymta.info
    2. Log into My MTA Portal
    3. Select "*My Benefits*"
    4. Select the "*FMLA Request/Status*" folder
    5. If it's your first time, complete the page and select *"Save"* on the bottom left of the form
    6. If it's not your first time, select the **"+"** sign on the top right, complete the page and select *"Save"* on the bottom left of the form
    7. Whether it's your first time or not, in the *"Comments"* section, please put your phone number and email address
- To submit the **HR-BEN-069, HR-BEN-070** forms – Email Complianceandsupport@nyct.com

FMLA FAQS

What is the application process and how long does it take to get a decision?

- The FMLA unit will verify your eligibility.
- You will receive an initial letter from the BSC informing you of your eligibility status.
- The second letter from the BSC will let you know if your medical certification was approved/denied by Occupational Health Services (OHS).
- The process takes approximately **30 days or more**.

How can I check my FMLA request status?

- BSC Employee self-service website – www.mymta.info
- Click on *"My Benefits"*
- Click on *"FMLA Request/Status"*
- Email FMLA Unit – SubwaysFMLA@nyct.com

How soon should I make my initial notification to my employer/FMLA Coordinator-Subways FMLA Unit of my need for FMLA?

- **Employees must give 30-days' advance notice of the need for FMLA before the leave date.** If it is not possible to give 30-days' notice, an employee must notify the employer/FMLA Coordinator-Subways FMLA Unit as soon as possible.

When using FMLA, do I have to use my time?

- Yes. You must use your available time.

How do I call out FMLA once approved?

- You will call the same number(s) you currently call yourself out sick or request a day, but you must state you're using an FMLA day and who the FMLA is for, meaning you're calling out FMLA sick for self or FMLA for spouse, parent, or child for family.

If I have FMLA, why do I have to submit a sick form?

- Employees using FMLA leave are required to follow all notice and procedural requirements for requesting leave in the Authority's time and leave rules, and appropriate collective bargaining agreements, including submission of sick leave policies and contractual procedures.

If I have approved FMLA for a family member, do I need to provide a sick form?

- No. If you go out FMLA for a family member, you are not going out sick, therefore, you do not need to provide a sick form.

Do the 60 days renew once a new year begins?

- Everyone's situation is different. FMLA time is based on a 12-month rolling period. If you have time remaining from the 60 FMLA days from your previous years' usage, that remaining time will carry over and can be used once you're approved for your new FMLA requested time. Then, as you pass the FMLA days you used for the prior year, those FMLA days become available to you again to be used, but be mindful that as you take FMLA days, your time will continue to decrease.
- If you exhausted all of your 60 FMLA days, you may be denied due to FMLA Entitlement Exhausted.

YOU MUST INCLUDE YOUR TITLE, NAME, PASS # AND BSC # IN THE SUBJECT OR BODY OF ALL EMAILS SENT TO SUBWAYSFMLA@NYCT.COM OR COMPLIANCEANDSUPPORT@NYCT.COM.

April 10, 2024