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 or 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 with a spouse, son, daughter, or parent on active duty or call to active duty status in the National Guard or Reserves in support of a contingency operation 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 servicemember during a single 12-month period. A covered servicemember is a current member of the Armed Forces, including a member of the National Guard or Reserves, who has a serious injury or illness incurred in the line of duty on active duty that may render the servicemember medically unfit to perform his or her duties for which the servicemember is undergoing medical treatment, recuperation, or therapy; or is in outpatient status; or is on the temporary disability retired list.

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 one year, for 1,250 hours over the previous 12 months, and if at least 50 employees are employed by the employer within 75 miles.

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;
- 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. Regulations 29 C.F.R. § 825.300(a) may require additional disclosures.

Certification of Physician or Practitioner
(Family and Medical Leave Act of 1993)

Instructions: To be completed by Practitioner or Physician only. **PLEASE PRINT CLEARY**

1. Employee's Name	2. Patient's Name (if other than employee)
_____	_____

3. The attached sheet describes what is meant by a "serious health condition" under the Family and Medical Leave Act. Does the patient's condition[1] qualify under any of the categories described? If so, please check the applicable category.

(1) ☐ (2) ☐ (3) ☐ (4) ☐ (5) ☐ (6) ☐

☐ None of the above

4. Please state the diagnosis _____ and describe the medical facts which support your certification, including a brief statement as to how the medical facts meet the criteria of one of these categories.

_____
_____
_____

5. Date condition commenced _____
   a. Probable duration of condition (and also the probable duration of the patients' present incapacity[2] if different)
   _____
   b. Will it be necessary for the employee to take work only intermittently or to work on a less than full schedule as a result of the condition (including for treatment described in Item 6 below)? If yes, give the probable duration.[2]
   _____
   c. If the condition is a chronic condition (condition 4) or pregnancy, state whether the patient is presently incapacitated and the likely duration and frequency of episodes of incapacity.
   _____

6. a. If additional treatments will be required for the condition, provide an estimate of the probable number of such treatments.
   _____
   b. If the patient will be absent from work or other daily activities because of treatment on an intermittent or part-time basis, also provide an estimate of the probable number and interval between such treatments, actual or estimated dates of treatment if known, and period required for recovery if any. _____
   _____
   c. If any of these treatments will be provided by another provider of health services (e.g., physical therapist), please state the nature of the treatments.
   _____
   _____

[1] Here and elsewhere on this form, the information sought relates only to the condition for which the employee is taking FMLA leave.

[2] "Incapacity" for purposes of FMLA, is defined to mean inability to work, attend school or perform other regular daily activities due to the serious health condition, treatment therefor, or recovery therefrom.

Continuation

Employee's Name	Patient's Name (if other than employee)
_____	_____

d. If a regimen of continuing treatment by the patient is required under your supervision, provide a general description of such regimen (e.g., prescription drugs, physical therapy requiring special equipment).

_____
_____
_____

7. a. If medical leave is required for the employee's absence from work because of the employee's own condition (including absences due to pregnancy or a chronic condition), is the employee unable to perform work of any kind? ☐ Yes ☐ No
What are the medical conditions that interfere with the employee performing their assigned duties:

_____
_____
_____

b. If able to perform some work within their title please list the functions the employee is able to perform.

_____
_____
_____
_____
_____

c. If neither a. nor b. applies, is it necessary for the employee to be absent from work for treatment? ☐ Yes ☐ No

8. a. If leave is required to care for a family member of the employee with a serious health condition, does the patient require assistance for basic medical or personal needs or safety, or for transportation? ☐ Yes ☐ No

b. If no, would the employee's presence to provide psychological comfort be beneficial to the patient or assist in the patient's recovery? ☐ Yes ☐ No

c. If the patient will need care only intermittently or on a part-time basis, please describe the kind of care and indicate the probable duration of this need for care by the family member (i.e., the employee).

_____
_____
_____
_____

Continuation

Employee's Name	Patient's Name (if other than employee)
_____	_____

I have examined _____ and hereby certify that the above information is correct.

(Name)

_____

(Please print your first and last name)

_____ _____

(Signature of Health Care Provider & Date) (Type of Practice)

_____ _____

(Address) (Telephone number)

To be completed by the employee needing family leave to care for a family member:
State the care you will provide and an estimate of the period during which care will be provided. Include a schedule of date(s) and time(s) you will require leave if leave is to be taken intermittently or if it will be necessary for you to work less than a full schedule.

_____
_____
_____
_____
_____
_____

_____ _____

(Employee's signature & Pass #) (Date)

VOLUNTARY CONSENT

I _____, give permission for a health care provider representing the New York City Transit Authority, to contact the health care provider that signed my Family Medical Leave Act Medical Certification form, for the purpose of clarifying and/or validating authenticity of the medical certification. Any such inquiry pursuant to this authorization may not seek additional information regarding my health condition or that of a family member.

_____ _____

(Employee's signature & Pass #) (Date)

A **"Serious Health Condition"** means an illness, injury impairment, or physical or medical condition that involves one of the following:

1. Hospital Care

Inpatient care (i.e., an overnight stay) in a hospital, hospice or residential medical care facility, including any period of incapacity[1] or subsequent treatment in connection with or consequent to such inpatient care.

2. Absence Plus Treatment

(a) A period of incapacity[1] of more than three consecutive calendar days (including any subsequent treatment or period of incapacity[1] relating to the same condition), that also involves:

(1) Treatment[2] two or more times by a health care provider, by a nurse or physician's assistant under direct supervision of a health care provider, or by a provider of health care services (e.g., physical therapist) under orders of, or on referral by, a health care provider; or

(2) Treatment by a health care provider on at least one occasion which results in a regimen of continuing treatment[3] under the supervision of the health care provider.

3. Pregnancy

Any period of incapacity due to pregnancy, or for prenatal care.

4. Chronic Conditions Requiring Treatments

A chronic condition which:

(1) Requires periodic visits for treatment by a health care provider, or by a nurse or physician's assistant under direct supervision of a health care provider;

(2) Continues over an extended period of time (including recurring episodes of a single underlying condition); and

(3) May cause episodic rather than a continuing period of incapacity[1] (e.g., asthma, diabetes, epilepsy, etc.).

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[1] "Incapacity", for purposes of FMLA, is defined to mean inability to work, attend school or perform other regular daily activities due to the serious health condition, treatment therefor, or recovery therefrom.

[2] Treatment includes examinations to determine if a serious health condition exists and evaluations of the condition. Treatment does not include routine physical examinations, eye examinations or dental examinations.

[3] A regimen of continuing treatment includes, for example, a course of prescription medication (e.g., an antibiotic) or therapy requiring special equipment to resolve or alleviate the health condition. A regimen of treatment does not include the taking of over-the–counter medications such as aspirin, antihistamines, or salves; or bed-rest, drinking fluids, exercise, and other similar activities that can be initiated without a visit to a health care provider.

5. Permanent/Long-term Conditions Requiring Supervision

A period of incapacity[1] which is permanent or long-term due to a condition for which treatment may not be effective. The employee or family member must be under the continuing supervision of, but need not be receiving active treatment by, a health care provider. Examples include Alzheimer's, a severe stroke, or the terminal stages of a disease.

6. Multiple Treatments (Non-Chronic Conditions)

Any period of absence to receive multiple treatments (including any period of recovery therefrom) by a health care provider or by a provider of health care services under orders of, or on referral by, a health care provider, either for restorative surgery after an accident or other injury, or for a condition that would likely result in a period of incapacity[1] of more than three consecutive calendar days in the absence of medical intervention or treatment, such as cancer (chemotherapy, radiation, etc.) severe arthritis (physical therapy), kidney disease (dialysis).

NOTE: Ordinarily, unless complications arise, the common cold, the flu, ear aches, upset stomach, minor ulcers, headaches other than migraines, routine dental or orthodontia problems, periodontal disease, etc., are examples of conditions that **DO NOT** meet the definition of a serious health condition and **DO NOT** qualify for FMLA leave.

(Attachment A)

New York City Transit Authority
Staten Island Rapid Transit Operating Authority
Manhattan & Bronx Surface Transit Operating Authority

REQUEST AND NOTIFICATION FOR FAMILY AND MEDICAL LEAVE

DEPARTMENT: _____ RC NO./DIVISION: _____ DATE: _____

NAME: _____ TITLE: _____ RDO: _____

PASS NO: _____ SOCIAL SECURITY NO. (LAST 4 DIGITS): _____

1. REASON FOR REQUESTING FMLA LEAVE:

_____ My own serious health condition renders me unable to perform the functions of my position.
_____ The birth of a child and in order to care for such a child.
_____ The adoption of a child or placement of a child for foster care.
_____ Serious health condition of your: child, spouse, parent.

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2. Requested Absence from the Authority

From: _____, 20 _____ (A.M./P.M.) To: _____, 20 _____ (A.M./P.M.) Total No. of days: _____

_____ Intermittent Leave

_____ Reduced Leave Schedule

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3. I understand that if the leave requested is for my own serious health condition or that of a family member, I must provide medical certification within 15 calendar days of completing this form and that my failure to do so will result in denial of my leave until such certification is provided. The medical certification must be submitted to ***Occupational Health Services, Attention: Compliance and Support Unit, 180 Livingston Street, Room 4023, Brooklyn, New York 11201.***

4. I understand that I may be required to submit additional certification at least once every 30 calendar days as requested by the Authority and that failure to comply with this request within 15 days may result in the Authority denying continuation of my leave.

5. If this leave is requested for the birth, adoption or placement of a foster child, I agree to provide the Authority with the appropriate documentation substantiating such request within 15 calendar days of completing this form.

6. I understand that, unless I am notified otherwise, this leave will be counted against my annual Family and Medical Leave entitlement.

7. I understand that when taking FMLA leave, the Authority will require that I use all applicable paid leave. Such paid leave will be counted against my annual Family and Medical leave entitlement of 12 weeks.

8. If I currently make contributions for my health benefits, I understand that the Authority will continue to make these contributions on my behalf and deduct such payments from my wages upon my return from FMLA leave. I understand that if I fail to return to work after my leave, I may be liable for payment of health insurance premiums paid by the Authority during my FMLA leave.

9. If my leave request is for my own serious illness, I understand that I will be required to provide the Authority with a certification from my health care provider that I am physically able to return to work.

10. I understand that when I return from FMLA leave, the Authority will place me in the same position or an equivalent position to the one in which I am presently employed.

11. I understand that a fraudulent FMLA request will subject me to immediate dismissal.

12. I understand that while I am on FMLA leave I may not apply for or receive Unemployment Insurance Benefits.

13. I acknowledge that I have received a copy of this form for my records.

_____ Acknowledged: _____ Pass No: _____ _____

Employee's Signature | Supervisor | Date

(If in an emergency situation, information received by:)

Name: _____ Title: _____ Date: _____

Request Acknowledged/Approved/Denied (circle one)

_____ _____

Deputy Medical Director | Date

_____ _____

Department Head | Date