

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	Suffix	BSC ID:	
Employer (check one)	<input type="checkbox"/> BSC	<input type="checkbox"/> B&T	<input type="checkbox"/> CC	<input type="checkbox"/> HQ	<input type="checkbox"/> Police	Department:
	<input type="checkbox"/> SIR	<input type="checkbox"/> LIRR	<input type="checkbox"/> MNR	<input type="checkbox"/> MTA Bus	<input type="checkbox"/> NYCTA	
Street Address						
City				State	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:	
<input type="checkbox"/> 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: _____

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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



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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
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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
<input type="checkbox"/>	<p><u>MTA & MTA Capital Construction</u> MTA Medical Department Occupational Health Services 420 Lexington Avenue, Suite 2201 New York, NY 10017 Attn: Nurse Manager</p>
<input type="checkbox"/>	<p><u>LIRR</u> Human Resources Department 93-02 Sutphin Boulevard Jamaica, NY 11435</p>
<input type="checkbox"/>	<p><u>Metro-North Railroad</u> FMLA Administrator Human Resources 347 Madison Avenue, 4th Floor New York, NY 10017</p>
<input type="checkbox"/>	<p><u>Staten Island Railroad (SIR)</u> Human Resources Department 60 Bay Street Staten Island, NY 10301</p>
<input type="checkbox"/>	<p><u>NYCT / MaBSTOA / MTA BUS</u> Occupational Health Services 180 Livingston Street Brooklyn, NY 11201</p>