

# FMLA Certification for Serious Injury or Illness of Covered Service Member



HR-BEN-072

**Section I – 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](http://www.mymta.info). If you are unable to apply online, mail 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 must forward completed forms to the BSC at fax# 212-852-8700 or [bscservice@mtabsc.org](mailto:bscservice@mtabsc.org)).

**For Completion by the EMPLOYEE and/or the COVERED SERVICE MEMBER for whom the Employee Is Requesting Leave.**  
 Please complete Section II before having Section III 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](mailto:bscservice@mtabsc.org).

**Section II – Employee Information**

**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	Suffix	BSC ID:
									Agency 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	<input type="checkbox"/> NYCT		Department:	
	<input type="checkbox"/> SIR	<input type="checkbox"/> LIRR	<input type="checkbox"/> MNR	<input type="checkbox"/> MTA Bus		<input type="checkbox"/> MaBSTOA		Job Title:	
Street Address								Regular Work Schedule:	
City							State	Zip Code	
Phone (H)			Phone (W)			Email			
Name of Covered Service Member (for whom employee is requesting leave to care for):									
Last			First			M.I		Suffix	
Relationship of Employee to Covered Service member requesting Leave to Care for:									
<input type="checkbox"/> Spouse <input type="checkbox"/> Parent <input type="checkbox"/> Son <input type="checkbox"/> Daughter <input type="checkbox"/> 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

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 Retired List (TDRL)? \_\_\_\_ Yes \_\_\_\_ No

# FMLA Certification for Serious Injury or Illness of Covered Service Member



HR-BEN-072

## 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 III – Instructions to the United States Department of Defense (“DOD”) Provider / Healthcare Provider

**SECTION II: For Completion by a UNITED STATES DEPARTMENT OF DEFENSE (“DOD”) HEALTH CARE PROVIDER or a HEALTH 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 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. **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 II above has been completed before completing this section.) **Please be sure to sign the form on page 3.**

## 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: \_\_\_\_\_

# 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 (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.
  - 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: \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_

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

# FMLA Certification for Serious Injury or Illness of Covered Service Member



HR-BEN-072

## Section V – 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.

Check the box for your agency.	Agency Name, Address, and Contact Information <i>Note: Bridges and Tunnels employees should contact their agency Human Resources Department</i>
<input type="checkbox"/>	<p><b><u>MTA-HQ</u></b> Occupational Health Services 420 Lexington Avenue, Suite 2201 New York, NY 10170 Attn: Nurse Manager Email: <a href="mailto:STDB@MTAHQ.ORG">STDB@MTAHQ.ORG</a> Fax: 212-878-0266</p>
<input type="checkbox"/>	<p><b><u>MTA-Bridges and Tunnels</u></b> Bridges and Tunnels 2 Broadway -24<sup>th</sup> Floor New York, NY 10004 Attn: FMLA Unit</p>
<input type="checkbox"/>	<p><b><u>MTA- Long Island Rail Road</u></b> Human Resources Department 93-02 Sutphin Boulevard Jamaica, NY 11435 Attention: FMLA Administrator Fax: 718-558-6824 Email: <a href="mailto:fmla@lirr.org">fmla@lirr.org</a></p>
<input type="checkbox"/>	<p><b><u>MTA– Metro-North Railroad</u></b> FMLA Administrator Human Resources Department 420 Lexington Avenue, 12<sup>th</sup> Floor New York, NY 10170 Attention: FMLA Administrator Phone: 212-340-2112 Fax: 212-340-2045 Email: <a href="mailto:mnrFMLA@mnr.org">mnrFMLA@mnr.org</a></p>
<input type="checkbox"/>	<p><b><u>MTA- NYCT / MaBSTOA/ SIRTOA/ MTABUS</u></b> Occupational Health Services 180 Livingston Street, Room 4023 Brooklyn, NY 11201 Attention: Office of the Medical Director</p>