FMLA Certification of Health Care Provider
Family Member's Serious Health Condition

HR-BEN-070

Section I – Instructions for the Employee

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

Please complete Section I before giving this form to your family member or his/her medical 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 to care for a covered family member with a 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. 29 C.F.R. § 825.313. Your employer must give you at least 15 calendar days to return this form to your employer. 29 C.F.R. § 825.305.

If you have any questions, please contact MTA Business Service Center (BSC) at 646-376-0123 or bscservice@mtabsc.org.

Section II – Employee Information

Print Name	Last		First		M	Suffix	BSC ID:
Employer (check one)	☐ BSC	☐ B&T	☐ CC	☐ HQ	☐ Police	☐ MaBSTOA	Department:
	☐ SIR	☐ LIRR	☐ MNR	☐ MTA Bus	☐ NYCTA		Job Title:
Street Address							Regular Work Schedule
City					State		Zip Code
Phone (H)		Phone (W)			Email		
Name of Family Member for whom you will provide care:		Relationship of family member to you: Parent ☐ Spouse ☐ Child ☐ If son or daughter, date of birth:					
Describe the care you will provide to your family member and estimate leave needed to provide care:							
Employee Signature					Date _____/_____/_____		

Section III – For Completion by the HEALTH CARE PROVIDER

The employee listed above has requested leave under the FMLA to care for your patient. Answer, fully and completely, all appl icable 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 patient needs leave. Page 3 provides space for additional information, should you need it. **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).**

Please be sure to sign the form on page 3.

Provider's Name:	License number:	State:
Type of Practice/ Medical Specialty:		
Provider's Address:		
City:	State:	Zip Code:
Telephone:	Fax:	

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PART A: MEDICAL FACTS

1. Approximate date condition commenced: _____

   Probable duration of condition: _____

   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: _____

   Was medication, other than over-the-counter medication, prescribed? ___No ___Yes

   Will the patient need to have treatment visits at least twice per year due to the condition? ___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. Describe other relevant medical facts, if any, related to the condition for which the patient needs care (such medical facts may include symptoms, diagnosis, or any regimen of continuing treatment such as the use of specialized equipment):

   _____

   _____

   _____

   _____

PART B: AMOUNT OF CARE NEEDED:

When answering these questions, keep in mind that your patient's need for care by the employee seeking leave may include assistance with basic medical, hygienic, nutritional, safety or transportation needs, or the provision of physical or psychological care:

4. Will the patient be incapacitated for a single continuous period of time, including any time for treatment and recovery? ___No ___Yes

   Estimate the beginning and ending dates for the period of incapacity: _____

   During this time, will the patient need care? ___ No ___Yes

   Explain the care needed by the patient and why such care is medically necessary:

   _____

   _____

   _____

   _____

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5. Will the patient require follow-up treatments, including any time for recovery? ___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:

_____

Explain the care needed by the patient, and why such care is medically necessary:

_____

6. Will the patient require care on an intermittent or reduced schedule basis, including any time for recovery? ___No ___Yes

Estimate the hours the patient needs care on an intermittent basis, if any:

_____hour(s) per day; _____days per week from _____through _____

Explain the care needed by the patient, and why such care is medically necessary:

_____

_____

7. Will the condition cause episodic flare-ups periodically preventing the patient from participating in normal daily activities? ____No ____Yes

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

Does the patient need care during these flare-ups? _____No _____Yes

Explain the care needed by the patient, and why such care is medically necessary:

_____

_____

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.	
Signature	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
☐	**MTA-HQ** Occupational Health Services 420 Lexington Avenue, Suite 2201 New York, NY 10170 Attn: Nurse Manager Email: marian.sanders@nyct.com Tel: 212-499-4739 Fax: 212-878-0266
☐	**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** Occupational Health Services 180 Livingston Street, Room 4023 Brooklyn, NY 11201 Attention: Office of the Medical Director