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 *(NAZWISKO, IMIE - TY WYPELNIASZ / last, first name)*	Last	First	M.I.	Suffix		BSC ID# *(TY)*	Pass# (NYCT/MTA Bus) *(TY)*
Agency/ Dept (Check only one)	☐ BSC	☐ B&T	☐ C&D	☐ HQ	☐ Police	Department MOW - Infrastructure	
	SIR	☐ LIRR	☐ MNR	☐ MTA Bus	NYCT	Job Title Light Maintainer	
					☐ MaBSTOA	Reg. Work Schedule 22:00-06:00 (Sob-Sr)	
Street Address *(TY)*							
City *(TY)*					State *(TY)*	Zip Code *(TY)*	
Phone (H) *(TY)*		Phone (W) *(TY)*				Email *(TY)*	

Family and Medical Leave Act Request Form

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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):	✓
(zaznacz obok tez: spouse / child / parent - kogo dotyczy) 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 *(TY)*	Leave End Date *(TY)*

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 *(PODPIS - podpisz tutaj / sign here)*	Date *(TY)*

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 of Health Care Provider Family Member's Serious Health Condition

HR-BEN-070

Section 1 - Information and Instructions

The purpose of this form is to submit the required documentation for your FMLA request.

NOTE: 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, you must complete the HR-BEN-028 form 30 days prior to the start of your leave or as soon as possible. See the instructions at the top of the form for how to submit it to your agency.

Please complete Section 2-4 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 this certification is 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 regarding the above, please contact your agency Human Resources Department.

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

Section 2 - Employee Information

Print Name *(NAZWISKO, IMIE - TY WYPELNIASZ)*	Last		First		M	Suffix	BSC ID: *(TY)*	
Employer (check one)	☐ BSC	☐ B&T	☐ C&D	☐ HQ	☐ Police	☐ MaBSTOA	Department: MOW - Infrastructure	
	☐ SIR	☐ LIRR	☐ MNR	☐ MTA Bus	☑ NYCT		Job Title: Light Maintainer	
Street Address *(TY)*							Regular Work Schedule 22:00-06:00 (Sob-Sr)	
City *(TY)*				State *(TY)*			Zip Code *(TY)*	
Phone (H) *(TY)*			Phone (W or M) *(TY)*				Email *(TY)*	
Name of Family Member for whom you will provide care: *(TY - imie i nazwisko czlonka rodziny)*							Relationship of family member to you ☐ Parent ☐ Spouse ☐ Child If son or daughter, date of birth: *(zaznacz: Parent/Spouse/Child)*	

Describe the care you will provide to your family member:

PRZYKLAD: opisz jaka opieke bedziesz zapewniac / EXAMPLE: describe the care

Section 3 - Request for Leave

Leave Start Date *(TY)*	Leave End Date *(TY)*

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

Employee Signature	Date

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

HR-BEN-070

(NIE TY - wypelnia lekarz / NOT YOU - health care provider fills sections 5-6)

Section 5 - To be completed by the HEALTH CARE PROVIDER

The employee listed above has requested leave under the FMLA to care for your patient. 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 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 4.

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:

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:

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

☐ No ☐ Yes If so, estimate the beginning and ending dates for the period of incapacity:

Begin Date: End Date:

During this time, will the patient need care?

☐ No ☐ Yes

If so, explain the care needed by the patient and why such care is medically necessary:

2. 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:

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

☐ No ☐ Yes If so, 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:

4. 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) day(s)

Duration: Hours or 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(S) WITH YOUR ADDITIONAL ANSWER.

Section 6 – 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 of Health Care Provider
Family Member's Serious Health Condition

Section 7 – Agency Contact	
Check the box for your agency.	**Submit this form to your 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: 212-656-1368
☐	**MTA Bridges and Tunnels** Human Resources Department 1 Robert Moses Building Randall's Island, NY 10035 Attn: Leave Administration Fax: 646-252-7911 Phone: 212-360-2946/2950
☐	**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