MTA New York City Transit
Manhattan & Bronx Surface Transit Operating Authority

TO BE PREPARED IN DUPLICATE

Application for Leave of Absence Due to Illness

DEPARTMENT DZIAŁ RC#/DIVISION DYWIZJA Date 08/26 20 26

Name IMIE NAZWISKO Title STANOWISKO RDO PT/SB Pass No. NR PASS

Absent from 8/26, 20 26, A.M. P.M. to 8/27, 20 26, A.M. P.M. inclusive for a total of 1 working days.

I was unfit for work on account of illness during this period and request a paid/unpaid (circle as appropriate) leave of absence because (state nature of disability):

(PRZYKLAD - opisz tu powod, np. "grypa / infekcja gornych drog oddechowych")

Did this disability arise as a result of a service connected incident? Yes/No

Name of treating physician *(print)* Address *(print)* Telephone No.

Employee's Signature (PODPIS) Received: Supervisor Pass No. Date

Failure to submit this application within three (3) days after returning to work will result in loss of pay for the period in question and may also result in disciplinary action against the employee. Where absence is for more than two (2) days, this certification must be completely filled out by the attending physician before sick leave with pay will be approved. OA employees should be guided by the applicable section of the collective bargaining agreement to determine when a physician's certification is required.

DOCTOR'S CERTIFICATION

I hereby certify that *Employee's Name* was treated by me on the date/s and for illness noted below:

Dates of treatment: Home Office Hospital

DIAGNOSIS/OBJECTIVE FINDINGS

TREATMENT/PROGNOSIS AND EXPECTED DATE OF RETURN

I further certify that this illness so incapacitated this employee that he/she was incapable of performing his/her duties during the period from: to, and that the information in this section, which will be used for payment purposes, is truthful.

Physician Stamp

Date

Physician's Signature/Tax ID No.

TO BE PREPARED IN DUPLICATE — DEPARTMENT MUST COMPLETE REVERSE SIDE

58-60-0329 8/00

Reference copy pre-filled by MTA Work Log - get a fresh official form from twulocal100.org before submitting.

DEPARTMENTAL REFERRAL TO ABSENTEE CONTROL

REASON FOR REFERRAL
(check box if appropriate)

Remarks _____

☐ Review for incomplete certification
☐ Review for fraudulent/altered certification
☐ Review - is period of absence consistent with illness? Reviewed by _____ _____ _____
☐ Other: _____ *Name* *Date*

LAST 12 MONTH USAGE REPORT		SICK LEAVE BANK BALANCE		ACTION ON APPLICATION
Substantiated Instances	Unsubstantiated Instances	Prior to Request	Post Request	Approved Paid _____ Days _____ Hours Unpaid _____ Days _____ Hours Disapproved _____ Days _____ Hours
☐	☐	☐	☐	

Sick Leave Control List _____ Yes/No Signature _____
Department Head or Designee

Reason for Disapproval: _____

Signature _____

58-60-0329b