NJ TRANSIT

FOR CORPORATE, POLICE AND RAIL EMPLOYEES
NOT FOR BUS EMPLOYEES*

Certification of Health Care Provider for EMPLOYEE'S SERIOUS HEALTH CONDITION Family and Medical Leave Act

The Family and Medical Leave Act (FMLA) provides that an employer may require an employee seeking FMLA protections because of a need for leave due to a serious health condition that makes the employee unable to perform the functions of his/her job to submit a medical certification issued by the employee's health care provider.

PLEASE ATTACH A COMPLETED LEAVE OF ABSENCE REQUEST WITH THIS FORM.
IT IS YOUR RESPONSIBILITY TO RETURN THIS FORM TO NJ TRANSIT.

Section I - For Completion by the EMPLOYEE:
Instructions:
Please complete this section 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. Your response is required to obtain or retain the benefits of FMLA protections. Failure to provide a complete and sufficient medical certification may result in a delay or denial of your FMLA request.

- **Corporate and Police:** FMLA Administrator, 180 Boyden Avenue, Room 101, Maplewood NJ 07040 Phone: 973-378-6085.
- **Rail Employees:** Manager, Rail Administration, 1 Penn Plaza E., 3rd Floor, Newark NJ 07105 Phone: 973-491-7535.
- ***Bus Employees should contact Bus Administration,** 1 Penn Plaza E., 3rd Floor, Newark NJ 07105 Phone: 973-491-7976.

Your name: _____ Employee #_____
First Middle Last

Your job title: _____ Regular work schedule: _____

By signing this form, I hereby request my health care provider complete all applicable parts of this certification.

_____ _____
Employee's Signature **Date**

Section II - To be Completed by the HEALTH CARE PROVIDER:

Instructions:

Your patient has requested leave under the FMLA. 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 is seeking leave. Page 4 provides space for additional information, should you need it.

PLEASE BE SURE TO SIGN THE FORM (Page 4) AND RETURN IT TO THE PATIENT, NOT TO NJ TRANSIT.

Health Care Provider's name and business address _____

_____

Type of practice/Medical specialty: _____

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 this 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 this 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 yes, expected delivery date: _____

3. Answer these questions based upon the patient's description of his/her job functions. If you need additional information on the essential functions of the job, please contact Medical Services at 973-378-6854.

   Is the patient unable to perform any of his/her job functions due to the condition: No _____ Yes _____

   If so, identify the job functions the patient is unable to perform: _____

   _____

4. Describe other relevant medical facts, if any, related to the condition for which the patient 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 patient 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 patient need to attend follow-up treatment appointments or work part-time or on a reduced schedule because of his/her medical condition? No _____ Yes _____

   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 intermittent or reduced work schedule the patient needs, if any:

   _____ hour(s) per day _____ days per week from _____ through _____

7. Will the condition cause episodic flare-ups periodically preventing the patient from performing his/her job functions? No _____ Yes _____

   Is it medically necessary for the patient 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 (s)he may have over the next six (6) months (e.g., one (1) episode every three (3) months lasting 1-2 days):

Frequency: _____ times per _____ week(s) _____ month(s)

Duration: _____ hours or _____ day(s) per episode

Additional Information: Identify the Question Number with Your Additional Answer.

_____

_____

_____

_____

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Signature of Health Care Provider **Date**

PLEASE RETURN COMPLETED CERTIFICATION TO THE PATIENT, NOT TO NJ TRANSIT. IT IS HIS OR HER RESPONSIBILITY TO RETURN THIS CERTIFICATION TO NJ TRANSIT.

NJTRANSIT
The Way To Go.

LEAVE OF ABSENCE REQUEST
CORPORATE, POLICE AND RAIL EMPLOYEES ONLY

Last Name	First Name	Middle Initial	Employee #
Job Title	Department	Mgt Center	Payroll (Circle One) CORPORATE POLICE RAIL
Home Address		Home Phone	Personal E-Mail Address (Optional)
Work Location		Work Phone	Work Email Address

PERIOD OF LEAVE REQUESTED: **Start Date** _____ (MM/DD/YYYY) **End Date** _____ (MM/DD/YYYY)

REASON FOR LEAVE: (Check all that apply) (FMLA AND/OR FLA)	ADDITIONAL DOCUMENTATION REQUIRED:
☐ **Bonding with child or placement for adoption or foster care**	▪ Birth certificate, Court Order or Letter from adoption or foster agency
☐ **Employee's own illness/injury/incapacity or due to pregnancy or prenatal care** ☐ Consecutive (Full-time) ☐ Intermittent/Reduced Leave schedule (FMLA only)	▪ Medical certification of serious health condition
☐ **Illness/injury of Employee's Family Member:** (Write name on appropriate line below) ▪ **Spouse** _____ ▪ **Parent** _____ ▪ **Child** _____ **Child's Date of Birth** ____/____/____ ▪ **Domestic Partner** _____ ▪ **Civil Union Partner** _____ ☐ Consecutive (Full-time) ☐ Intermittent/Reduced Leave schedule	▪ Medical certification of serious health condition <u>in all cases</u> ▪ Plus Certificate of Domestic Partnership ▪ Plus NJ Civil Union Certificate or valid certification from another jurisdiction that recognizes same-sex civil unions
☐ **Military Family Leave** ☐ **For qualifying exigencies due to covered family member's active military duty** Covered family members are an employee's spouse, son, daughter, or parent ☐ **For employee to care for a covered service member recovering from a serious injury or illness sustained in the line of duty** Employee must be service member's spouse, son, daughter, parent or next of kin (i.e., nearest blood relation) ☐ Consecutive (Full-time) ☐ Intermittent/Reduced leave schedule	▪ Appropriate certification (to be designated by U.S. Dept. of Labor) ▪ Medical certification of serious health condition

<u>PLEASE RETURN COMPLETED FORM TO</u>:

- **Corporate and Police:** FMLA Administrator, 180 Boyden Avenue, Rm 101, Maplewood NJ 07040. Phone: 973-378-6085.
- **Rail Employees:** Manager, Rail Administration, 1 Penn Plaza E., 3rd Floor, Newark NJ 07105. Phone: 973-491-7535.

REASON FOR LEAVE:	ADDITIONAL DOCUMENTATION REQUIRED:
☐ **Military Duty** ☐ **Component of the Military** _____ (i.e., National Guard, Air Force, etc.) ☐ **Type of Duty Performed** _____	▪ Copy of military orders or drill schedule
☐ **Interagency/Government Exchange**	▪ Memorandum of Agreement between employee, the Receiving Agency and NJ TRANSIT
☐ **Personal**	▪ Letter or memorandum of explanation
☐ **Other:**_____	▪ Letter or memorandum of explanation

I understand that if the requested leave is granted, it will be governed by the following terms and conditions:

- **Employee Responsibilities** - It is my responsibility to determine my specific rights and entitlements under any applicable labor agreement, benefit plan or NJ TRANSIT policy prior to taking a leave of absence and to comply with the requirements and procedures governing the particular type of leave being requested.
- **Documentation** - NJ TRANSIT reserves the right to require additional documentation in order to make a determination with respect to a leave request (e.g., a marriage certificate to establish a covered relationship for purposes of FMLA or FLA leave). Leaves will not be approved without proper documentation.
- **Family and Medical Leave** - All or part of the requested leave may be designated as FMLA and/or FLA leave and counted toward any FMLA or FLA leave allowance(s) for which I am eligible.
- **Leave Coordination** - Paid sick leave, temporary disability and workers compensation will run concurrently with an FMLA-qualifying and designated absence and will be counted against any FMLA leave allowance for which I am eligible.
- **Intermittent FMLA/FLA Leave** - If qualified for intermittent leave under the FMLA and/or FLA, I must make every reasonable effort to schedule my leave use so as not to unduly disrupt my department's operations and I must provide my supervisor with advance notice of all foreseeable use of leave (i.e., for scheduled medical appointments).
- **Benefits Continuation** - My benefits coverage will continue for a specified period of time in accordance with applicable laws, NJ TRANSIT policies, benefit plans and/or labor agreement provisions. Depending on the type of leave, I may be responsible for paying some or all of the cost of my benefits to ensure the continuation of my coverage. I understand that it is my responsibility to make payment arrangements with NJ TRANSIT's Benefits Department and that failure to make timely payments may result in the cancellation of my coverage.
- **Approval** - All leaves are conditioned on my meeting the requirements of the applicable labor agreement, NJ TRANSIT policy and law. Final authority regarding all leave issues rests with NJ TRANSIT's Human Resources Department.
- **Return to Work** – I understand that if I fail to return to work upon the expiration of an approved leave, my employment with NJ TRANSIT may be terminated. A Fitness for Duty report from my physician will be required before I will be permitted to return to work from a leave due to my own illness and I must be cleared to return to work by Medical Services before returning to work after any absence of more than 30 calendar days.

By signing this form, I agree to the terms and conditions outlined above.

_____ _____

Employee Signature **Date**

To be completed by Employee's SUPERVISOR:

Leave Request Received _____ MM/DD/YYYY

During the 12 months preceding the requested leave, has/will employee have worked at least ____ 1000 hours? At least ____ 1250 hours?

Supervisor: _____ _____ _____

Print Name Signature Date

APPROVALS:

Department AED/VPGM _____ **Date** _____

Human Resources_____ **Date** _____

Medical Services _____ **Date** _____

Executive Director** _____ **Date** _____

** Required for Interagency/Government Exchange leaves