

# Your Rights under the Family and Medical Leave Act of 1993

FMLA requires covered employers to provide up to 12 weeks of unpaid, job-protected leave to "eligible" employees for certain family and medical reasons. Employees are eligible if they have worked for their employer for at least one year, and for 1,250 hours over

the previous 12 months, and if there are at least 50 employees within 75 miles. The FMLA permits employees to take leave on an intermittent basis or to work a reduced schedule under certain circumstances.

## Reasons for Taking Leave:

Unpaid leave must be granted for *any* of the following reasons:

- to care for the employee's child after birth, or placement for adoption or foster care;
- to care for the employee's spouse, son or daughter, or parent who has a serious health condition; or
- for a serious health condition that makes the employee unable to perform the employee's job.

At the employee's or employer's option, certain kinds of *paid* leave may be substituted for unpaid leave.

## Advance Notice and Medical Certification:

The employee may be required to provide advance leave notice and medical certification. Taking of leave may be denied if requirements are not met.

- The employee ordinarily must provide 30 days advance notice when the leave is "foreseeable."
- An employer may require medical certification to support a request for leave because of a serious health condition, and may require second or third opinions (at the employer's expense) and a fitness for duty report to return to work.

## Job Benefits and Protection:

- For the duration of FMLA leave, the employer must maintain the employee's health coverage under any "group health plan."

- Upon return from FMLA leave, most employees must be restored to their original or equivalent positions with equivalent pay, benefits, and other employment terms.
- The use of FMLA leave cannot result in the loss of any employment benefit that accrued prior to the start of an employee's leave.

## Unlawful Acts by Employers:

FMLA makes it unlawful for any employer to:

- interfere with, restrain, or deny the exercise of any right provided under FMLA;
- discharge or discriminate against any person for opposing any practice made unlawful by FMLA or for involvement in any proceeding under or relating to FMLA.

## Enforcement:

- The U.S. Department of Labor is authorized to investigate and resolve complaints of violations.
- An eligible employee may bring a civil action against an employer for violations.

FMLA does not affect any Federal or State law prohibiting discrimination, or supersede any State or local law or collective bargaining agreement which provides greater family or medical leave rights.

## For Additional Information:

If you have access to the Internet visit our FMLA website: <http://www.dol.gov/esa/whd/fmla>. To locate your nearest Wage-Hour Office, telephone our Wage-Hour toll-free information and help line at 1-866-4USWAGE (1-866-487-9243): a customer service representative is available to assist you with referral information from 8am to 5pm **in your time zone**; or log onto our Home Page at <http://www.wagehour.dol.gov>.



U.S. Department of Labor  
Employment Standards Administration  
Wage and Hour Division  
Washington, D.C. 20210

WH Publication 1420  
Revised August 2001

## METRO-NORTH RAILROAD FAMILY AND MEDICAL LEAVE ACT REQUEST/NOTIFICATION FORM

<b>1. EMPLOYEE NAME</b>	<b>2. EMPLOYEE #</b>	<b>3. DEPARTMENT</b>
-------------------------	----------------------	----------------------

**4. I AM REQUESTING A LEAVE OF ABSENCE PURSUANT TO THE METRO-NORTH FAMILY AND MEDICAL LEAVE POLICY FOR THE FOLLOWING REASON (CHECK ONE):**

THE BIRTH AND CARE OF A CHILD; OR

THE PLACEMENT OF A CHILD WITH YOU FOR ADOPTION OR FOSTER CARE; OR

MY OWN SERIOUS HEALTH CONDITION THAT RENDERS ME UNABLE TO PERFORM THE ESSENTIAL FUNCTIONS OF MY POSITION; OR

A SERIOUS HEALTH CONDITION AFFECTING  SPOUSE,  CHILD,  PARENT, FOR WHICH YOU ARE NEEDED TO PROVIDE CARE.

**5. I AM REQUESTING THE FOLLOWING LEAVE:**

DATE LEAVE WILL START: \_\_\_\_\_

NUMBER OF WEEKS: \_\_\_\_\_

INTERMITTENT LEAVE: (PLEASE SPECIFY DATES UPON WHICH LEAVE IS TO BE TAKEN)  
\_\_\_\_\_

REDUCED SCHEDULE LEAVE: (PLEASE SPECIFY SCHEDULE REQUESTED) \_\_\_\_\_

### PLEASE READ • IMPORTANT INFORMATION

(1) IF THIS LEAVE IS REQUESTED FOR THE BIRTH, ADOPTION OR PLACEMENT OF A FOSTER CHILD, I AGREE TO PROVIDE THE COMPANY WITH APPROPRIATE DOCUMENTATION SUBSTANTIATING SUCH REQUEST **WITHIN 15 CALENDAR DAYS** OF COMPLETING THIS FORM.

(2) I UNDERSTAND THAT IF THE LEAVE REQUESTED IS FOR MY OWN SERIOUS HEALTH CONDITION OR THAT OF A FAMILY MEMBER, I MUST PROVIDE MEDICAL CERTIFICATION **WITHIN 15 CALENDAR DAYS** OF COMPLETING THIS FORM. MY FAILURE TO DO SO MAY RESULT IN THE DENIAL OF MY LEAVE UNTIL SUCH CERTIFICATION IS PROVIDED.

- (3) I UNDERSTAND THAT THIS LEAVE WILL BE COUNTED AGAINST MY ANNUAL FAMILY AND MEDICAL LEAVE ENTITLEMENT.
- (4) I UNDERSTAND THAT I MAY SUBSTITUTE PAID LEAVE UNDER OTHER APPLICABLE METRO-NORTH POLICIES FOR UNPAID LEAVE UNDER THE FAMILY AND MEDICAL LEAVE POLICY AND THAT METRO-NORTH WILL REQUIRE THAT I USE ALL SUCH PAID LEAVE. SUCH PAID LEAVE WILL BE COUNTED AGAINST MY ANNUAL FAMILY AND MEDICAL LEAVE ENTITLEMENT OF 12 WEEKS.
- (5) IF YOU NORMALLY PAY A PORTION OF THE PREMIUMS FOR YOUR HEALTH INSURANCE, THESE PAYMENTS WILL CONTINUE DURING THE PERIOD OF FAMILY AND MEDICAL LEAVE. I UNDERSTAND THAT I WILL BE REQUIRED TO MAKE PREMIUM PAYMENTS AT PRE-LEAVE CONTRIBUTION LEVELS IN ORDER TO MAINTAIN ANY OPTIONAL OR SUPPLEMENTAL HEALTH BENEFITS. I WISH TO MAKE SUCH PAYMENTS AS FOLLOWS:
- I WISH TO BE BILLED ON A MONTHLY BASIS BY METRO-NORTH.
- I WISH TO MAKE SUCH PAYMENTS IN ADVANCE OF MY LEAVE.
- I UNDERSTAND THAT IF I FAIL TO MAKE SUCH PAYMENTS, THE COMPANY WILL DEDUCT SUCH PAYMENTS FROM MY WAGES UPON MY RETURN FROM LEAVE. I UNDERSTAND THAT IF I FAIL TO RETURN TO WORK AFTER MY LEAVE, I WILL BE LIABLE FOR PAYMENT OF HEALTH INSURANCE PREMIUMS PAID BY METRO-NORTH DURING MY LEAVE.***
- (6) IF THE LEAVE REQUESTED IS FOR MY OWN SERIOUS HEALTH CONDITION, I UNDERSTAND THAT I WILL BE REQUIRED TO PROVIDE A FITNESS-FOR-DUTY CERTIFICATION TO RETURN TO WORK.
- (7) I UNDERSTAND THAT WITHIN 30 DAYS OF SUBMITTING THIS FORM, THE COMPANY MAY ADVISE ME THAT I AM A "KEY EMPLOYEE" AND IF SO, THAT I MAY BE DENIED RESTORATION TO METRO-NORTH UNDER CERTAIN CIRCUMSTANCES.
- (8) WHILE ON LEAVE, I UNDERSTAND THAT I MUST REPORT **EVERY 30 DAYS** ON MY STATUS AND INTENT TO RETURN TO WORK. IF THE CIRCUMSTANCES OF MY LEAVE CHANGE AND I AM ABLE TO RETURN TO WORK EARLIER, I WILL NOTIFY MY SUPERVISOR AT LEAST TWO WORK DAYS PRIOR TO THE DATE INTENDED TO RETURN.
- (9) A FAMILY AND MEDICAL LEAVE REQUEST THAT IS BASED ON FRAUD WILL BE SUBJECT TO DISCIPLINE, UP TO AND INCLUDING DISMISSAL.
- (10) FINALLY, I ACKNOWLEDGE THAT I HAVE RECEIVED A COPY OF THIS FORM FOR MY RECORDS.

EMPLOYEE'S SIGNATURE

DATE

**REVIEWED**

EMPLOYEE'S SUPERVISOR

DATE

**APPROVED**

DIRECTOR OF HUMAN RESOURCES

DATE

COMPLETE THIS FORM, HAVE IT SIGNED BY THE SUPERVISOR IN CHARGE OF YOUR SHOP/WORK LOCATION AND RETURN IT TO ZANETTA JOHNSON, 347 MADISON AVENUE, 4<sup>TH</sup> FLOOR, NEW YORK, NY 10017

## CERTIFICATION OF HEALTH CARE PROVIDER

---

**PLEASE COMPLETE, SIGN AND RETURN THIS FORM TO ZANETTA JOHNSON, HUMAN RESOURCES SPECIALIST**  
**MTA METRO-NORTH RAILROAD, 347 MADISON AVENUE, 4TH FLOOR, NEW YORK, NY 10017**  
**TELEPHONE (212) 340-3088 • FAX (212) 340-3040**

---

1. Employee's Name	Employee #	2. Patient's Name <i>(If different from employee)</i>
--------------------	------------	---

---

3. Page 4 describes what is meant by a “**serious health condition**” under the Family and Medical Leave Act. Does the patient’s condition<sup>1</sup> qualify under any of the categories described? If so, please check the applicable category.

(1) \_\_\_\_\_ (2) \_\_\_\_\_ (3) \_\_\_\_\_ (4) \_\_\_\_\_ (5) \_\_\_\_\_ (6) \_\_\_\_\_ , or None of the above \_\_\_\_\_

---

4. Describe the **medical facts** which support your certification, including a brief statement as to how the medical facts meet the criteria of one of these categories:

---

5. a. State the approximate **date** the condition commenced, and the probable duration of the condition (and also the probable duration of the patient’s present **incapacity**<sup>2</sup> if different):

b. Will it be necessary for the employee to take work only **intermittently or to work on a less than full schedule** as a result of the condition (including for treatment described in Item 6 below)?

If yes, give the probable duration:

c. If the condition is a **chronic condition** (condition #4) or **pregnancy**, state whether the patient is presently incapacitated<sup>2</sup> and the likely duration and frequency of **episodes of incapacity**<sup>2</sup>:

---

<sup>1</sup> Here and elsewhere on this form, the information sought relates **only** to the condition for which the employee is taking FMLA leave.

<sup>2</sup> “Incapacity,” for purposes of FMLA, is defined to mean inability to work, attend school or perform other regular daily activities due to the serious health condition, treatment therefor, or recovery therefrom.

---

---

6. a. If additional **treatments** will be required for the condition, provide an estimate of the probable number of such treatments.

If the patient will be absent from work or other daily activities because of **treatment** on an **intermittent** or **part-time** basis, also provide an estimate of the probable number of and interval between such treatments, actual or estimated dates of treatment if known, and period required for recovery if any:

b. If any of these treatments will be provided by **another provider of health services** (e.g., physical therapist), please state the nature of the treatments:

c. **If a regimen of continuing treatment** by the patient is required under your supervision, provide a general description of such regimen (e.g., prescription drugs, physical therapy requiring special equipment):

---

7. a. If medical leave is required for the employee's **absence from work** because of the **employee's own condition** (including absences due to pregnancy or a chronic condition), is the employee **unable to perform work** of any kind?

b. If able to perform some work, is the employee **unable to perform any one or more of the essential functions of the employee's job** (the employee or the employer should supply you with information about the essential job functions)?  
If yes, please list the essential functions the employee is unable to perform:

c. If neither a. nor b. applies, is it necessary for the employee to be **absent from work for treatment**?

---

8. a. If leave is required to **care for a family member** of the employee with a serious health condition, **does the patient require assistance** for basic medical or personal needs or safety, or for transportation?

b. If no, would the employee's presence to provide **psychological comfort** be beneficial to the patient or assist in the patient's recovery?

c. If the patient will need care only **intermittently** or on a part-time basis, please indicate the probable **duration** of this need:

---

Name of Health Care Provider

---

License #

---

Signature of Health Care Provider

---

Type of Practice

---

Address

---

Telephone Number

---

Date

---

**To be completed by the Employee needing Family Leave to care for a family member:**

State the care you will provide and an estimate of the period during which care will be provided, including a schedule if leave is to be taken intermittently or if it will be necessary for you to work less than a full schedule:

---

Employee Signature

---

Date

---

A “**Serious Health Condition**” means an illness, injury impairment, or physical or mental condition that involves one of the following:

1. Hospital Care

**Inpatient care** (*i.e.*, an overnight stay) in a hospital, hospice, or residential medical care facility, including any period of incapacity<sup>2</sup> or subsequent treatment in connection with or consequent to such inpatient care.

2. Absence Plus Treatment

(a) A period of incapacity 2 of **more than three consecutive calendar days** (including any subsequent treatment or period of incapacity<sup>2</sup> relating to the same condition), that also involves:

- (1) **Treatment<sup>3</sup> two or more times** by a health care provider, by a nurse or physician’s assistant under direct supervision of a health care provider, or by a provider of health care services (*e.g.*, physical therapist) under orders of, or on referral by, a health care provider; or
- (2) **Treatment** by a health care provider on **at least one occasion** which results in a **regimen of continuing treatment<sup>4</sup>** under the supervision of the health care provider.

3. Pregnancy

Any period of incapacity due to **pregnancy**, or for **prenatal care**.

4. Chronic Conditions Requiring Treatments

A **chronic condition** which:

- (1) Requires **periodic visits** for treatment by a health care provider, or by a nurse or physician’s assistant under direct supervision of a health care provider;
- (2) Continues over an **extended period of time** (including recurring episodes of a single underlying condition); and
- (3) May cause **episodic** rather than a continuing period of incapacity<sup>2</sup> (*e.g.*, asthma, diabetes, epilepsy, etc.).

5. Permanent/Long-term Conditions Requiring Supervision

A period of **Incapacity<sup>2</sup>** which is **permanent or long-term** due to a condition for which treatment may not be effective. The employee or family member must be **under the continuing supervision of, but need not be receiving active treatment by, a health care provider**. Examples include Alzheimer’s, a severe stroke, or the terminal stages of a disease.

6. Multiple Treatments (Non-Chronic Conditions)

Any period of absence to receive **multiple treatments** (including any period of recovery therefrom) by a health care provider or by a provider of health care services under orders of, or on referral by, a health care provider, either for **restorative surgery** after an accident or other injury, **or** for a condition that **would likely result in a period of Incapacity<sup>2</sup> of more than three consecutive calendar days in the absence of medical intervention or treatment**, such as cancer (chemotherapy, radiation, etc.), severe arthritis (physical therapy), and kidney disease (dialysis).

This optional form may be used by employees to satisfy a mandatory requirement to furnish a medical certification (when requested) from a health care provider, including second or third opinions and recertification (29 CFR 825.306).

*Note:* Persons are not required to respond to this collection of information unless it displays a currently valid OMB control number.

---

<sup>3</sup> Treatment includes examinations to determine if a serious health condition exists and evaluations of the condition. Treatment does not include routine physical examinations, eye examinations, or dental examinations.

<sup>4</sup> A regimen of continuing treatment includes, for example, a course of prescription medication (*e.g.*, an antibiotic) or therapy requiring special equipment to resolve or alleviate the health condition. A regimen of treatment does not include the taking of over-the-counter medications such as aspirin, antihistamines, or salves; or bed-rest, drinking fluids, exercise, and other similar activities that can be initiated without a visit to a health care provider.

---