CAPITAL DISTRICT TRANSPORTATION AUTHORITY

Date: _____

To: _____

From: _____

On _____, you informed CDTA that you needed leave beginning on _____ for:

_____ The birth of a child, or placement of a child with you for adoption or foster care;

_____ Your own serious health condition;

_____ Because you are needed to care for your spouse, child or parent due to his/her serious health condition.

_____ Because of a qualifying necessity arising out of you, your spouse, child, or parent on covered active duty or call to covered active duty status with Armed Forces.

_____ Because you are the spouse, child parent or next of kin of a covered service member with a serious injury or illness.

_____ You did not state why your leave was necessary

This notice is to inform you:

_____ eligibility for FMLA leave is pending upon completion of the attached FMLA Medical Certification form (please read below instructions).

_____ do not meet the requirements to be eligible for FMLA as you have not met requirements outlined below however, you may still qualify for short term disability and sick leave.

(Continued on page 2)

110 Watervliet Avenue
Albany, N.Y. 12206

If your FMLA eligibility is pending, please see the attached Medical Certification form to be completed by your physician. This form should be returned to the Benefits Coordinator within **15 days** of receipt of this package, as per CDTA policy.

- To be eligible for FMLA you must have been employed by CDTA for at least one year or worked at least 1,250 hours. Please see the attached Employees Rights and Responsibilities Under the Family Medical Leave Act

The attached Sick Leave Entitlement Form is to be filled out in order to collect your sick leave benefit.

- A copy of the sick leave entitlement form must be completed and returned to the division Administrative Assistant by 10:00 a.m. on Monday in order to receive your appropriate sick leave by the Friday of that week. It is not necessary for the physician to complete this form if a note is attached that covers all days absent from work.

The attached Disability Claim Form is to be filled out in order to collect disability benefits and returned to the Benefits Coordinator within **15 days** of receipt of this package.

- Disability benefits can be applied starting with the 8th full consecutive day of absence. Please remember that if you are entitled to sick leave benefits, your sick leave will be based on the difference between your regular wages minus your disability benefit. You will receive a separate check from CDTA's insurance carrier for your disability benefit.

All employees out of work for more than five (5) full consecutive working days must complete and submit a Return to Work Form to the division Administrative Assistant in order to return to active duty.

- The top portion of this form is to be completed by you and the rest of the form is to be completed by your attending physician. Please alert your physician to state on the form the diagnosis as well as completing the limitations section and to sign the form.

You are required to report to the division Superintendent periodically if you are out of work for ninety (90) consecutive days or more. All employees on medical leave, compensable or non-compensable, shall report personally or if not possible to report in person then in writing, to the Superintendent at least every ninety (90) days. These reports must be made to your Department Head or designee.

All employees off duty more than (90) days must go to the company's doctor for certification to return to work.

Please remember that all forms submitted must be **filled out completely** and returned. Thank you for your cooperation.

If you have any questions, please contact Meredith Redcross, Benefits Coordinator at 518-437-8382.

CDTA

FMLA LEAVE REQUEST FORM

Name: _____ **ID #:** _____

I request leave for:

- ☐ For birth of my child and/or to care for the newborn child.
- ☐ For placement of a child with me for adoption or foster care.
- ☐ To care for my (circle one): spouse, child or parent with a serious health condition.
  Name: _____
- ☐ My own serious health condition.
- ☐ For another reason (Please specify):

_____

_____

_____

☐ I request a leave of absence from _____ (date) to _____ (date)

☐ I request intermittent leave or schedule-reduced leave at the following times:

Schedule: _____

Reason: _____

I can be reached at the following address and phone number during my leave:

Address: _____ Phone: _____

Employee's Signature: _____ Date: _____

Approved By: _____ Date: _____
(Name) (Title)

3/18

Certification of Health Care Provider for Employee's Serious Health Condition (Family and Medical Leave Act)

U.S. Department of Labor
Wage and Hour Division

U.S. Wage and Hour Division

DO NOT SEND COMPLETED FORM TO THE DEPARTMENT OF LABOR; RETURN TO THE PATIENT

OMB Control Number: 1235-0003
Expires: 5/31/2018

SECTION I: For Completion by the EMPLOYER

INSTRUCTIONS to the EMPLOYER: 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 to submit a medical certification issued by the employee's health care provider. Please complete Section I before giving this form to your employee. Your response is voluntary. While you are not required to use this form, you may not ask the employee to provide more information than allowed under the FMLA regulations, 29 C.F.R. §§ 825.306-825.308. Employers must generally maintain records and documents relating to medical certifications, recertifications, or medical histories of employees created for FMLA purposes as confidential medical records in separate files/records from the usual personnel files and in accordance with 29 C.F.R. § 1630.14(c)(1), if the Americans with Disabilities Act applies, and in accordance with 29 C.F.R. § 1635.9, if the Genetic Information Nondiscrimination Act applies.

Employer name and contact: _____

Employee's job title: _____ Regular work schedule: _____

Employee's essential job functions: _____

_____

Check if job description is attached: _____

SECTION II: For Completion by the EMPLOYEE

INSTRUCTIONS to the EMPLOYEE: Please complete Section II before giving this form to your 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 due to your own 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. 20 C.F.R. § 825.313. Your employer must give you at least 15 calendar days to return this form. 29 C.F.R. § 825.305(b).

Your name: _____
First Middle Last

SECTION III: For Completion by the HEALTH CARE PROVIDER

INSTRUCTIONS to the HEALTH CARE PROVIDER: Your patient has requested leave under the FMLA. Answer, fully and completely, all applicable parts. 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 employee is seeking leave. 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 the last page.

Provider's name and business address: _____

Type of practice / Medical specialty: _____

Telephone: (_____)_____ Fax:(_____)_____

[redacted]

1. Approximate date condition commenced: _____

   Probable duration of condition: _____

   Mark below as applicable:
   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:

   _____

   Will the patient need to have treatment visits at least twice per year due to the condition? ___No ___ Yes.

   Was medication, other than over-the-counter medication, prescribed? ___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. Use the information provided by the employer in Section I to answer this question. If the employer fails to provide a list of the employee's essential functions or a job description, answer these questions based upon the employee's own description of his/her job functions.

   Is the employee unable to perform any of his/her job functions due to the condition: ____ No ____ Yes.

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

   _____

4. Describe other relevant medical facts, if any, related to the condition for which the employee seeks leave (such medical facts may include symptoms, diagnosis, or any regimen of continuing treatment such as the use of specialized equipment):

   _____

   _____

   _____

   _____

   _____

   _____

   _____

CONTINUED ON NEXT PAGE

[redacted]

5. Will the employee 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 employee need to attend follow-up treatment appointments or work part-time or on a reduced schedule because of the employee's 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 part-time or reduced work schedule the employee needs, if any:

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

7. Will the condition cause episodic flare-ups periodically preventing the employee from performing his/her job functions? ____No ____Yes.

   Is it medically necessary for the employee 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 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

[redacted]

_____

_____

_____

_____

_____

_____

Signature of Health Care Provider **Date**

PAPERWORK REDUCTION ACT NOTICE AND PUBLIC BURDEN STATEMENT

If submitted, it is mandatory for employers to retain a copy of this disclosure in their records for three years. 29 U.S.C. § 2616; 29 C.F.R. § 825.500. Persons are not required to respond to this collection of information unless it displays a currently valid OMB control number. The Department of Labor estimates that it will take an average of 20 minutes for respondents to complete this collection of information, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. If you have any comments regarding this burden estimate or any other aspect of this collection information, including suggestions for reducing this burden, send them to the Administrator, Wage and Hour Division, U.S. Department of Labor, Room S-3502, 200 Constitution Ave., NW, Washington, DC 20210. **DO NOT SEND COMPLETED FORM TO THE DEPARTMENT OF LABOR; RETURN TO THE PATIENT.**

SICK LEAVE REQUEST FORM

PHYSICIAN STATEMENT(Please complete all blanks) Date _____

Name _____ has been under my professional care from _____ to _____.

Injury or first symptoms appeared on _____

Diagnosis or current condition of patient _____

_____

Expected treatment duration _____ Return to work date _____

Physicians Name _____ Address _____

Phone Number _____ Signature _____

EMPLOYEE STATEMENT

Name _____ Payroll Number _____ Division _____

Address _____ Phone _____

Last Day Worked _____ Return to Work _____ Regular Days Off _____

Indicate if you were out of work due to: (check the one that applies)

Off-the-Job ( ) Illness ( ) Accident ( ) Motor Vehicle ( ) Yes ( ) No

On-the-Job ( ) Illness ( ) Accident ( ) Motor Vehicle ( ) Yes ( ) No

Signature _____ Date _____

FOR COMPLETION BY PERSONNEL DEPARTMENT

Hourly Wage _____ First Unable to Work _____

First 2 Working Days _____ Payable from _____

DATES	WEEKLY WAGE	LESS DISABILITY/COMP PAID	BBF	HOURS PAID

DB-450 9-17

New York State

NOTICE AND PROOF OF CLAIM FOR DISABILITY BENEFITS

Use this form if you became disabled **while employed** or if you became disabled **within four (4) weeks after termination of employment** OR if you became **disabled after having been unemployed for more than four (4) weeks**. Please answer all questions in Part A and questions 1 through 3 in Part B. Read all instructions on this form carefully. Health care providers must complete Part B on page 2.

PART A - CLAIMANT'S INFORMATION (Please Print or Type)

1. Last Name: _____ First Name: _____ MI: ___
2. Mailing Address: _____ Line 2: _____
   City: _____ State: _____ Zip: _____ Country: _____
3. Daytime Phone #: _____ 4. Email Address: _____
5. Social Security #: _____ - _____ - _____ 6. Date of Birth: ___ - ___ - _____ 7. Gender: ☐ Male ☐ Female
8. My disability is (if injury, also state how, when and where it occurred): _____
9. I became disabled or became ineligible for Unemployment Insurance because of this disability on: ____ / ____ / _____
   I worked on that day: ☐ Yes ☐ No
   Have you recovered from this disability? ☐ Yes ☐ No If Yes, what was the date you were able to work: ____ / ____ / _____
   Have you since worked for wages or profit? ☐ Yes ☐ No If Yes, list dates: _____
10. Give name of last employer. If more than one employer during last eight (8) weeks, name all employers. Average Weekly Wage is based on all wages earned in last eight (8) weeks worked.

LAST EMPLOYER			PERIOD OF EMPLOYMENT		Average Weekly Wage (Include Bonuses, Tips, Commissions, Reasonable Value of Board, Rent, etc.)
Firm or Trade Name	Address	Phone Number	First Day	Last Day Worked	
			Mo. Day Yr.	Mo. Day Yr.	
OTHER EMPLOYER (during last eight (8) weeks)			**PERIOD OF EMPLOYMENT**		**Average Weekly Wage (Include Bonuses, Tips, Commissions, Reasonable Value of Board, Rent, etc.)**
Firm or Trade Name	Address	Phone Number	First Day	Last Day Worked	
			Mo. Day Yr.	Mo. Day Yr.	
			Mo. Day Yr.	Mo. Day Yr.	

11. My job is or was: _____ (Occupation) 12. Union Member: ☐ Yes ☐ No If "Yes": _____ (Name of Union or Local Number)
13. Were you claiming or receiving unemployment prior to this disability? ☐ Yes ☐ No
    If you did not claim or if you claimed but did not receive unemployment insurance benefits after LAST DAY WORKED, explain reasons fully: _____
14. For the period of disability covered by this claim:
    A. Are you receiving wages, salary or separation pay: ☐ Yes ☐ No
    B. Are you receiving or claiming:
    1. Workers' compensation for work-connected disability: ☐ Yes ☐ No
    2. Paid Family Leave: ☐ Yes ☐ No
    3. No-Fault motor vehicle accident (check box): ☐ Yes ☐ No or personal injury involving third party (check box): ☐ Yes ☐ No
    4. Long-term disability benefits under the Federal Social Security Act for this disability: ☐ Yes ☐ No

IF "YES" IS CHECKED IN ANY OF THE ITEMS IN 14, COMPLETE THE FOLLOWING:

I have: ☐ received ☐ claimed from: _____ for the period: ____ / ____ / _____ to: ____ / ____ / _____

15. In the year (52 weeks) before your disability began, have you received disability benefits for other periods of disability? ☐ Yes ☐ No
    If "Yes", fill in the following: Paid by: _____ from: ____ / ____ / _____ to: ____ / ____ / _____
16. In the year (52 weeks) before your disability began, have you received Paid Family Leave? ☐ Yes ☐ No
    If "Yes", fill in the following: Paid by: _____ from: ____ / ____ / _____ to: ____ / ____ / _____

I hereby claim Disability Benefits and certify that for the period covered by this claim I was disabled. If my disability began while I was unemployed, I certify that I had been unemployed for more than four (4) weeks. I have read the instructions on page 2 of this form and that the foregoing statements, including any accompanying statements are, to the best of my knowledge, true and complete.

_____ (Claimant's Signature) _____ (Date)

An individual may sign on behalf of the claimant only if he or she is legally authorized to do so and the claimant is a minor, mentally incompetent or incapacitated. If signed by other than claimant, print information below and complete and submit Form OC-110A, Claimant's Authorization to Disclose Workers' Compensation Records.

_____ (On behalf of Claimant) _____ (Address) _____ (Relationship to Claimant)

PART B - HEALTH CARE PROVIDER'S STATEMENT (Please Print or Type)

THE HEALTH CARE PROVIDER'S STATEMENT MUST BE FILLED IN COMPLETELY. THE ATTENDING HEALTH CARE PROVIDER SHALL COMPLETE AND RETURN TO THE CLAIMANT WITHIN SEVEN (7) DAYS OF RECEIPT OF THIS FORM. For item 7-d, you must give estimated date. If disability is caused by or arising in connection with pregnancy, enter estimated delivery date in item 9. **INCOMPLETE ANSWERS MAY DELAY PAYMENT OF BENEFITS.**

1. Last Name: _____ First Name: _____ MI: ___

2.Gender: ☐ Male ☐ Female 3. Date of Birth: ___ / ___ / _____

4. Diagnosis/Analysis: _____ Diagnosis Code: _____

a. Claimant's symptoms: _____

_____

b. Objective findings: _____

_____

5. Claimant hospitalized?: ☐ Yes ☐ No From: ___ / ___ / _____ To: ___ / ___ / _____

6. Operation indicated?: ☐ Yes ☐ No a. Type _____ b. Date ___ / ___ / _____

7. ENTER DATES FOR THE FOLLOWING	MONTH	DAY	YEAR
a Date of your first treatment for this disability			
b. Date of your most recent treatment for this disability			
c. Date Claimant was unable to work because of this disability			
d. Date Claimant will again be able to perform work (Even if considerable question exists, estimate date. Avoid use of terms such as unknown or undetermined.)			
e. If pregnancy related, please check box and enter the date ☐ estimated delivery date OR ☐ actual delivery date			

8. In your opinion, is this disability the result of injury arising out of and in the course of employment or occupational disease?:
☐ Yes ☐ No If "Yes", has Form C-4 been filed with the Board? ☐ Yes ☐ No

I certify that I am a:

_____ _____ _____

(Physician, Chiropractor, Dentist, Podiatrist, Psychologist, Nurse-Midwife) **Licensed or Certified in the State of** **License Number**

_____ _____ _____

Health Care Provider's Printed Name **Health Care Provider's Signature** **Date**

_____ _____

Health Care Provider's Address **Phone #**

CLAIMANT: READ THESE INSTRUCTIONS CAREFULLY

PLEASE NOTE: Do not date and file this form prior to your first date of disability. In order for your claim to be processed, Parts A and B must be completed.

1. If you are using this form because you became disabled **while employed** or you became disabled **within four (4) weeks after termination of employment**, your completed claim should be mailed **within thirty (30) days to your employer or your last employer's insurance carrier.** You may find your employer's disability insurance carrier on the Workers' Compensation Board's website using Employer Coverage Search.

2. If you are using this form because you became **disabled after having been unemployed for more than four (4) weeks**, your completed claim should be mailed to: **Workers' Compensation Board, Disability Benefits Bureau, 328 State Street, Schenectady, NY 12305.** If you answered "Yes" to question 14.B.3, please complete and attach Form DB-450.1.

If you have any questions about claiming disability benefits, you may contact the Board's Disability Benefits Bureau at (800) 353-3092. Additional information may be obtained at the Board's website: www.wcb.ny.gov, or you may write to the Disability Benefits Bureau at the address listed above.

Notification Pursuant to the New York Personal Privacy Protection Law (Public Officers Law Article 6-A) and the Federal Privacy Act of 1974 (5 U.S.C. § 552a). The Workers' Compensation Board's (Board's) authority to request that claimants provide personal information, including their social security number, is derived from the Board's investigatory authority under Workers' Compensation Law (WCL) § 20, and its administrative authority under WCL § 142. This information is collected to assist the Board in investigating and administering claims in the most expedient manner possible and to help it maintain accurate claim records. Providing your social security number to the Board is voluntary. There is no penalty for failure to provide your social security number on this form; it will not result in a denial of your claim or a reduction in benefits. The Board will protect the confidentiality of all personal information in its possession, disclosing it only in furtherance of its official duties and in accordance with applicable state and federal law

HIPAA NOTICE - In order to adjudicate a workers' compensation claim or disability benefits claim, WCL 13-a(4)(a) and 12 NYCRR 325-1.3 require health care providers to regularly file medical reports of treatment with the Board and the insurance carrier or employer. Pursuant to 45 CFR 164.512 these legally required medical reports are exempt from HIPAA's restrictions on disclosure of health information.

Disclosure of Information: The Board will not disclose any information about your case to any unauthorized party without your consent. If you choose to have such information disclosed to an unauthorized party, you must file with the Board an original signed Form OC-110A, Claimant's Authorization to Disclose Workers' Compensation Records, or an original signed, notarized authorization letter. You may telephone your local WCB office to have Form OC-110A sent to you, or you may download it from our website, www.wcb.ny.gov. It can be found under Forms on the 'List of All Common Workers' Compensation Board Forms' web page. Mail the completed authorization form to the address listed above.

An employer or insurer, or any employee, agent, or person acting on behalf of an employer or insurer, who KNOWINGLY MAKES A FALSE STATEMENT OR REPRESENTATION as to a material fact in the course of reporting, investigation of, or adjusting a claim for any benefit or payment under this chapter for the purpose of avoiding provision of such payment or benefit SHALL BE GUILTY OF A CRIME AND SUBJECT TO SUBSTANTIAL FINES AND IMPRISONMENT.

CAPITAL DISTRICT TRANSPORTATION AUTHORITY

MEDICAL STATEMENT/UPDATE AND RETURN-TO-WORK FORM

TO BE COMPLETED BY EMPLOYEE:

EMPLOYEE ID# _____ EMPLOYEE NAME _____

DIVISION _____ DEPARTMENT _____

DATE OF INJURY/ILLNESS _____

IF INJURED, WHERE AND HOW DID IT HAPPEN

ARE YOU CURRENTLY RECEIVING SOCIAL SECURITY DISABILITY BENEFITS? YES____ N

I hereby authorize any hospital, physician, employee insurance company or other organization to release to CDTA or its authorized representative any and all information they may have with respect to any sickness or injury that is currently preventing me from performing the full function of my job. This includes past and present medical history, diagnosis, consultations, treatments, operative procedures, xrays and pathological findings relating to my current illness or injury. I agree that a photostat copy of this authorization shall be considered as effective as the original and that all of the information that I have provided is truthful and to the best of my knowledge.

EMPLOYEE SIGNATURE _____ DATE _____

TO BE COMPLETED BY PHYSICIAN:

DATE FIRST CONSULTED BY PATIENT: _____

DATE OF LAST APPOINTMENT: _____

DATE OF NEXT APPOINTMENT:

DIAGNOSIS OR CURRENT CONDITION OF PATIENT **(PLEASE BE SPECIFIC)**

WHAT IS THE REGIMINE OF CARE? IS THIS PERSON IN PHYSICAL THERAPY OR ANOTHER TYPE OF SPECIALIZED PROGRAM DESIGNED TO HEAL HIS/HER INJURY? IF YES, WHAT IS THE PROGRAM?

IF THIS PERSON IS IN THERAPY TO HEAL HIS INJURY, WHAT IS THE SCHEDULE OF THERAPY?

WHAT IS THE EXPECTED DATE OF RETURN TO WORK FOR THIS PERSON? (MUST BE AN ANTICIPATED DATE)
____/_____/_____

IS CONDITION RELATED TO EMPLOYMENT	YES		NO		

PATIENT WAS TOTALLY DISABLED				PATIENT WAS PARTIALLY DISABLED			
FROM:		TO:		FROM:		TO:	

REMARKS: (PARTIAL DISABILITY, WORK LIMITATIONS, MEDICATIONS, COMMENTS, ETC.)

MAY PATIENT CONTINUE AND/OR RESUME NORMAL DUTIES WITHOUT ANY LIMITATIONS? YES_____ NO_____		
	(IF NO, PLEASE EXPLAIN)	

DO YOU ANTICIPATE THIS PATIENT BEING ABLE TO COME BACK TO WORK AS A FULL TIME EMPLOYEE IN THE SAME POSITION THAT THEY HELD BEFORE THEIR INJURY/ILLNESS? YES_____ NO_____		
	(IF NO, PLEASE EXPLAIN)	

OTHER COMMENTS:

PHYSICIAN'S NAME (print): _____ **ADDRESS:** _____

SIGNATURE: _____

Original: Human Resources