MTA Bus Company

Application for Leave of Absence Due to Illness (Combined Sick Leave / Short Term Disability Form)

Depot: _____ Department: _____ Date _____ 20 _____

Name _____ Title _____ RDO _____ Pass No. _____

Absent from _____ ,20 _____ A.M. _____ P.M. to _____ , 20 _____ A.M. _____ P.M. Inclusive for a total of _____ 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 general nature of disability),

_____

_____

Are you receiving or claiming wages under:

(1) Workers' Compensation for work-connected disability _____ ___Yes ___No
(2) NYS Unemployment Insurance Benefits _____ ___Yes ___No
(3) Damages for personal injury _____ ___Yes ___No
(4) Benefits under the Federal Social Security Act for long-term disability _____ ___Yes ___No
(5) No-Fault Insurance Claim _____ ___Yes ___No

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

_____ *Employee's Signature* Received _____ *Supervisor* Pass No. _____ Date _____

Employees are strongly encouraged to submit this form within three (3) days after returning to work for each sick or short-term disability absence.

This application, with supporting medical documentation, must be submitted within fifteen (15) calendar days for a sick or short-term disability absence of three (3) days or more, or for sick absences before and/or after a holiday. Failure to timely submit medical documentation may result in loss of pay.

Timely submission of medical documentation is required for sick leave or holiday pay. In addition, reasonable periodic updates may be required for long term absences. Employees submitting this form acknowledges its contents and that such content may be verified by MTA Bus Company.

DOCTOR'S CERTIFICATION (For Doctor's/Doctor's Staff Use Only)

(This form should be completely filled out by your attending physician and/or authorized staff including stamp)

I hereby certify that _____ *Employee's Name* was treated or evaluated by me on the date/s indicated for an illness noted below:

Dates of treatment: Home _____ Office _____ Hospital _____

Was Surgery performed? ___Yes ___No If yes, date of Surgery: _____ Type of Surgery: _____

_____

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's Stamp & License Number

Date _____

_____

Physician's Signature/Tax ID No.