NJTRANSIT

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

Certification of Health Care Provider for
FAMILY MEMBER'S SERIOUS HEALTH CONDITION

The Family and Medical Leave Act (FMLA) and NJ Family Leave Act (FLA) provide that an employer may require an employee seeking FMLA and/or FLA protections because of a need for leave to care for a covered family member with a serious health condition to submit a medical certification issued by the health care provider of the covered family member.

Section I - For Completion by the EMPLOYEE:

Complete this section before giving this form to your family member or your family member's health care provider. The FMLA and FLA permits an employer to require an employee to submit a timely, complete and sufficient medical certification to support a request for leave to care for a covered family member with a serious health condition. Your response is required to obtain or retain the benefits of FMLA and FLA protections. Failure to provide a complete and sufficient medical certification may result in a denial or delay of your leave request.

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

- **Rail Agreement Employees:** Rail FMLA Department 1 Penn Plaza E. , 2nd Fl., Newark NJ 07105
  Phone: 973-491-7945 Email: RailFMLA@njtransit.com E-fax: 973-804-0219
- **Bus Agreement Employees:** Bus Administration 1 Penn Plaza E., 3rd Fl., Newark, NJ 07105
  Phone: 973-491-7919 Email: BusFMLA@njtransit.com E-fax: 973-232-4948
- **All Non Agreement and Police:** FMLA Administrator, 1 Penn Plaza E. , 2nd Fl., Newark NJ 07105
  Phone: 973-491-4212 Email: NonAgreementFMLA@njtransit.com

If you seek a reasonable accommodation pursuant to the New Jersey Law Against Discrimination or the Americans with Disabilities Act, please contact **RAinfo@njtransit.com**.

Employee Name: _____ Employee # _____
First M.I. Last

Your job title: _____ Your regular work schedule: _____

Manager Name: _____ Work Location: _____

Personal Email Address: _____ Personal Phone Number: _____

Name of family member for whom you will provide care: _____
First M.I. Last

Relationship of family member to you: _____ D.O.B. _____
(If family member is your child)

Do you have a spouse that currently is employed at NJ Transit? No ____ Yes ____

If yes, Provide your spouse's name: _____

By signing this form, I hereby request my healthcare provider complete all applicable parts of Section II of this certification.

_____ _____
Employee's Signature Date

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

Instructions:

The NJ TRANSIT employee listed above has requested leave to care for your patient. 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/FLA coverage.** Limit your responses to the condition for which the patient requires our employee's care and assistance. Page 4 provides space for additional information, should you need it.

PLEASE NOTE: The Genetic Information Nondiscrimination Act of 2008 (GINA) prohibits employers and other entities covered by GINA Title II from requesting or requiring genetic information of an individual or family member of the individual, except as specifically allowed by this law. To comply with this law, we are asking that you not provide any genetic information when responding to this request for medical information. "Genetic information" as defined by GINA, includes an individual's family medical history, the results of an individual's or family member's genetic tests, the fact that an individual or an individual's family member sought or received genetic services, and genetic information of a fetus carried by an individual or an individual's family member or an embryo lawfully held by an individual or family member receiving assistive reproductive services.

Part A: Medical Facts

1. State the approximate date the condition started or will start:_____

2. Provide your best estimate of how long the condition will last:_____

3. Dates you treated the patient for this condition in the previous 12 months:

   _____

4. For FMLA to apply, care of the patient must be medically necessary. Briefly describe the type of care needed by the patient (e.g, assistance with basic medical, hygienic, transportation needs, physical care or psychological comfort)

   _____

   _____

   _____

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

   NOTE: Common ailments are medical conditions which ordinarily, absent complications, do not qualify as serious health conditions, unless they otherwise meet the definition, including rendering the patient unable to perform one or more essential functions of the job. Examples include the common cold, flu, earache, upset stomach, minor ulcer, headache (other than migraine), routine dental or orthodontia, periodontal disease, cosmetic treatment for acne, plastic surgery, etc.

   _____

   _____

   _____

   _____

   _____

6. Please check the box(es) for the questions below, as applicable. For all box(es) checked, the amount of leave needed must be provided in **Part B**.

☐ **Inpatient Care**: The patient ☐has been / ☐is expected to be admitted for an overnight stay in a hospital, hospice, or residential medical care facility on the following date(s):

_____

☐ **Incapacity plus Treatment**: (e.g. outpatient surgery)
Due to the condition, the patient ☐has been/ ☐is expected to be incapacitated (for more than three consecutive, full calendar days) from _____ to _____ (mm/dd/yyyy).

The patient ☐was /☐will be seen on the following date(s):_____

The condition ☐has/ ☐has not also resulted in a course of continuing treatment under the supervision of a health care provider (e.g. prescription medication or therapy requiring special equipment)

☐ **Pregnancy**: The condition is pregnancy. List the expected delivery date: _____

☐ **Chronic Conditions**: (e.g. asthma, migraine headaches) Due to the condition, it is medically necessary for the patient to have treatment visits at least twice per year.

☐ **Permanent or Long Term Conditions**: (e.g. Alzheimer's, terminal stages of cancer) Due to the condition, incapacity is permanent or long term and requires the continuing supervision of a health care provider (even if active treatment is not being provided).

☐ **Conditions requiring Multiple Treatments**: (e.g. chemotherapy treatments, restorative surgery) Due to the condition, it is medically necessary for the patient to receive multiple treatments.

☐ **None of the above**: If none of the above condition(s) were checked, no additional information is needed. Go to Page 4 to sign and date the form.

Part B: Amount of Care Needed

For the medical condition(s) checked in **Part A**, complete all that apply. Several questions seek a response to the frequency and 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 if the benefits and protections of the FMLA apply.

1. Due to the condition, the patient☐ was/☐will be incapacitated for a single continuous period of time, including any time for treatment and recovery? No ____ Yes ____

   If so, provide your best estimate of the beginning date: _____ and end date _____

   During this time will the employee be needed to provide care to the patient? No ____ Yes ____

   Explain the care the employee will need to provide to the patient and why such care is medically necessary:

   _____

   _____

   _____

2. Due to the condition, the patient☐ had/☐will have planned medical treatments, follow-up appointments on the following dates:

_____

3. Due to the condition, the patient☐was/☐ will be referred to other health care provider(s) for evaluation or treatment.

State the nature of such treatments or Provider Specialty: _____
(e.g. cardiologist, physical therapy)

Provide your best estimate of the beginning date: _____ and end date _____ of treatments.

Estimate the frequency and duration of treatment schedule, if any, including the dates of any scheduled appointments and the time required for each appointment, including any recovery period:

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

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

4. Will the patient need care for the condition due to episodic flare-ups that periodically prevent the patient from participating in normal daily activities? No ____ Yes ____

If yes, explain the care needed by the patient as a result of episodic flare-ups, and why such care is medically necessary:

_____

_____

_____

5. Due to the condition it ☐ was/☐ is/ ☐ will be medically necessary for the employee to be absent from work to provide care for the patient on an **intermittent basis** (periodically) including for any episodes of incapacity (e.g. episodic flare-ups) No ____ Yes ____

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:
(e.g.: two (2) times per three (3) months for 1-2 days) per episode)

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

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

Additional Information: Identify Section and Question with additional response

_____

_____

_____

_____

_____

PLEASE RETURN COMPLETED CERTIFICATION TO THE PATIENT. IT IS THE RESPONSIBILITY OF THE EMPLOYEE SEEKING FMLA/FLA LEAVE TO RETURN THIS CERTIFICATION TO NJ TRANSIT.

By signing this form, I hereby certify that the information provided in all applicable parts of Section II of this medical certification (pages 2- pages 4) have been answered based upon the patient's medical history and knowledge of the condition by a designated official in my practice.

Health Care Provider's name: (Print) _____

Health Care Provider's business address: _____

Type of Practice / Medical Specialty: _____

Telephone: (____) _____ Fax: (___)_____ E-mail: _____

_____

Signature of Health Care Provider Date