

Depot \_\_\_\_\_ Department \_\_\_\_\_ Date \_\_\_\_\_ 20 \_\_\_\_\_

Name \_\_\_\_\_ Title \_\_\_\_\_ RDO \_\_\_\_\_ Pass No. \_\_\_\_\_  
A.M. \_\_\_\_\_ A.M. \_\_\_\_\_ working

Absent from \_\_\_\_\_, 20 \_\_\_\_\_, \_\_\_\_\_ P.M. to \_\_\_\_\_, 20 \_\_\_\_\_, \_\_\_\_\_ P.M. inclusive for a total of \_\_\_\_\_ 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).

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Did this illness arise as a result of a service connected incident? \_\_\_\_\_ Yes/No

Name of treating physician \_\_\_\_\_ Address \_\_\_\_\_ Telephone No. \_\_\_\_\_  
(print) (print)

\_\_\_\_\_  
Employee's Signature Received: \_\_\_\_\_ Supervisor Pass No. \_\_\_\_\_ Date \_\_\_\_\_

Failure to submit this application within three (3) days after returning to work may result in loss of pay and/or disciplinary action against the employee. Employees should be guided by the applicable section of the collective bargaining agreement to determine when a physician's certification is required. Employee's submitting this form acknowledge that the contents of this form may be verified by MTA Bus Company personnel.

Do Not Write Below This Line

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

(This form should be completely filled out by your attending physician including stamp)

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

Dates of treatment: Home \_\_\_\_\_ Office \_\_\_\_\_ Hospital \_\_\_\_\_

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 Stamp

Date \_\_\_\_\_

Physician's Signature/Tax ID No. \_\_\_\_\_

# Departmental Report

## Departmental Referral for Employee Availability

REASON FOR REFERRAL  
(check box if appropriate)

- Review for incomplete certification
- Review for fraudulent/altered certification
- Review-Is period of absences consistent with illness?
- Other \_\_\_\_\_

Remarks \_\_\_\_\_

Reviewed by \_\_\_\_\_  
Name Date

### LAST 12 MONTH USAGE REPORT

Substantiated  
Instances

Unsubstantiated  
Instances

### SICK LEAVE BANK BALANCE

Prior to  
Request

Post  
Request

### ACTION ON APPLICATION

Approved Paid \_\_\_\_\_ Days \_\_\_\_\_ Hours

Unpaid \_\_\_\_\_ Days \_\_\_\_\_ Hours

Disapproved \_\_\_\_\_ Days \_\_\_\_\_ Hours

Sick Leave Control List \_\_\_\_\_ Yes/No

Signature \_\_\_\_\_  
*Department Head or Designee*

Reason for Disapproval: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Signature \_\_\_\_\_