MTA New York City Transit
Manhattan & Bronx Surface Transit Operating Authority

Application for Leave of Absence Due to Illness

DEPARTMENT __________________ RC#/DIVISION __________________ 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 nature of disability):

____

____

____

Did this disability arise as a result of a service connected incident? ____________________________ Yes/No

Name of treating physician ________________________ Address ________________________ Telephone No. ____________
(print) (print)

____________________________ Received: ____________________________ Pass No. ____________ Date ____________
Employee's Signature Supervisor

Failure to submit this application within three (3) days after returning to work will result in loss of pay for the period in question and may also result in disciplinary action against the employee. Where absence is for more than two (2) days, this certification must be completely filled out by the attending physician before sick leave with pay will be approved. OA employees should be guided by the applicable section of the collective bargaining agreement to determine when a physician's certification is required.

DOCTOR'S CERTIFICATION

I hereby certify that ____ was treated by me on the date/s and for 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.

Date ________________________________

Physician Stamp

____
Physician's Signature/Tax ID No.

____________________ *General Disp. Processing / Then Employee Personnel File Copy* — **WHITE**

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