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

TO BE PREPARED IN DUPLICATE

Application for Leave of Absence Due to Illness

DEPARTMENT ________________ RC#/DIVISION ________________ Date ________________ 19 ________________

Name ________________ Title ________________ RDO ________ Pass No. ________________

Absent from ______, 19 ______, ______ A.M. P.M. to ______, 19 ______, ______ 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 ________________ *(print)* Address ________________ *(print)* Telephone No. ________________

________________ *Employee's Signature* Received: ________________ *Supervisor* Pass No. ________ Date ________

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 ________________ *Employee's Name* was treated by me on the date/s and for illness noted below:

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.

TO BE PREPARED IN DUPLICATE — DEPARTMENT MUST COMPLETE REVERSE SIDE

6) 58-60-0327 2/97