New York City Transit Authority
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 illness 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.

Do Not Write Below This Line

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

I hearby 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.

To be prepared in duplicate

Department must complete on reverse side

Departmental Report

Departmental Referral to Absentee Control

REASON FOR REFERRAL
(check box if appropriate)

Remarks _____

☐ Review for incomplete certification

☐ Review for fraudulent/altered certification

☐ Review-is period of absences consistent with illness?

☐ Other _____

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 _____

58-60-0331(REV. 10/08)