(*) INDICATES REQUIRED FIELD – FORM MAY NOT BE PROCESSED FOR PAYMENT IF LEFT BLANK - KEEP COPY OF COMPLETED FORM FOR YOUR RECORD

PER 19
Updated 7/1/05

MASSACHUSETTS BAY TRANSPORTATION AUTHORITY
STATEMENT OF CLAIM FOR SICK LEAVE ALLOWANCE

TOP SECTION TO BE COMPLETED BY EMPLOYEE

*NAME _____ *EMPLOYEE # _____

*ADDRESS _____
*NUMBER *STREET *CITY *STATE *ZIP

PHONE _____ DATE OF HIRE _____

*JOB TITLE _____ *LOCATION AREA # _____

*REGULAR SCHEDULED DAYS OFF (PLEASE CIRCLE): SAT SUN MON TUE WED THU FRI VARY

EMPLOYEE MUST HAVE 5 YEARS SERVICE WITH THE AUTHORITY TO QUALIFY FOR THE FOLLOWING:

☐ **I WISH TO USE 1ST DAY SICK PAY**

☐ **I WISH TO USE MY ONE OCCASION ABSENCE W/O MEDICAL DOCUMENTATION**
(NOTE: You must also request 1st Day Sick Pay if you wish to be paid from the first day of this absence)

*FIRST FULL DAY OF ABSENCE _____ *HAVE YOU RETURNED TO WORK? YES ☐ NO ☐
*DATE

*IF YES, RETURN DATE _____ OR, IF NO, EXPECTED RETURN DATE _____

*IS DISABILITY DUE TO AN INJURY? YES ☐ NO ☐ *DATE OF ACCIDENT _____

*IS DISABILITY DUE TO A WORK RELATED INCIDENT? YES ☐ NO ☐ *AGGRAVATED ASSAULT? YES ☐ NO ☐

*IF AN INJURY, PLEASE GIVE A BRIEF DESCRIPTION OF THE INCIDENT: _____

_____

When this form is completed by BOTH Employee and Attending Physician, it should be submitted to:
MBTA Sick Leave Coordinator
10 Park Plaza, 4th Floor, Rm 4810, Boston, MA 02116
Phone (617) 222-3278 Fax (617) 222-4768

*EMPLOYEE'S SIGNATURE _____
SIGNATURE AUTHORIZES RELEASE OF *REQUIRED MEDICAL INFORMATION

*DATE _____

BOTTOM SECTION TO BE COMPLETED BY ATTENDING PHYSICIAN EMPLOYEE DO NOT WRITE BELOW

*THIS IS TO CERTIFY THAT _____
* NAME OF PATIENT

*HAS BEEN UNABLE TO WORK FROM _____
*BEGIN DISABILITY DATE

*☐ PATIENT IS ABLE TO RETURN TO WORK ON _____ OR,
*RETURN TO WORK W/O RESTRICTION DATE – NO VAGUE TERMS ACCEPTED

*☐ PATIENT WILL REMAIN OUT OF WORK UNTIL RE-EVALUATED ON _____
*DATE OF FOLLOW-UP APPOINTMENT

*NATURE OF ILLNESS _____

*PROGNOSIS _____

*TREATMENT _____

IF HOSPITALIZED, NAME OF HOSPITAL _____

DATE/TIME ADMITTED: _____ *DATE/TIME DISCHARGED:* _____

NOTE: THE PRECEDING INFORMATION MAY BE USED TO DETERMINE AN EMPLOYEE'S ELIGIBILITY FOR A LEAVE OF ABSENCE UNDER THE FAMILY AND MEDICAL LEAVE ACT (FMLA) OF 1993.

_____
*ATTENDING PHYSICIAN'S SIGNATURE

_____
*PHYSICIAN'S NAME (PLEASE PRINT)

_____ _____
*DATE *NUMBER STREET *CITY * STATE *ZIP

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