PER 19 - EST
Updated 8/11/15

MASSACHUSETTS BAY TRANSPORTATION AUTHORITY
STATEMENT OF CLAIM FOR "EARNED SICK TIME"

*NAME _____ *EMPLOYEE # _____ * UNION/AFFILIATION _____

*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

*FIRST FULL DAY OF ABSENCE _____
*DATE

*HAVE YOU RETURNED TO WORK? YES ☐ NO ☐

*IF YES, RETURN DATE _____
*DATE

IF NO, EXPECTED RETURN DATE _____
*DATE

*IS ILLNESS DUE TO AN INJURY? YES ☐ NO

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

_____

_____

IS ILLNESS DUE TO A WORK RELATED INCIDENT? YES ☐ NO ☐

DATE OF INCIDENT _____

IF WORK-RELATED, WAS THE INCIDENT AGGRAVATED ASSAULT? YES ☐ NO ☐

EMPLOYEE MUST COMPLETE AND SIGN THIS SECTION TO VERIFY A CLAIM FOR EARNED SICK TIME

Under the Massachusetts Earned Sick Time Law (M.G.L. c. 149, § 148C), employers are permitted to ask employees to verify that an instance of sick leave of any length was used for an authorized purpose under the law.

I attest that I used earned sick time for the authorized reason/s checked below:

☐ to care for my child, spouse, parent, or parent of my spouse, who is suffering from a physical or mental illness, injury, or medical condition that requires home care, professional medical diagnosis or care, or preventative medical care;

☐ to care for my own physical or mental illness, injury, or medical condition that requires home care, professional medical diagnosis or care, or preventative medical care;

☐ to attend a routine medical appointment or a routine medical appointment for my child, spouse, parent, or parent of my spouse;

☐ to address the psychological, physical, or legal effects of domestic violence; or

☐ to travel to and from an appointment, a pharmacy, or other location related to the purpose for which the time was taken.

I used earned sick time on the following date/s: _____.
DATE(s)

I understand that if an employee is committing fraud or abuse by engaging in an activity that is not consistent with allowable purposes for earned sick time under M.G.L. c. 149, § 148C, an employer may discipline the employee for misuse of sick leave.

I understand that if an employee is exhibiting a clear pattern of taking leave on days just before or after a weekend, vacation or holiday, an employer may discipline the employee for misuse of earned sick time, unless the employee provides verification of authorized use under M.G.L. c. 149, § 148C.

*EMPLOYEE'S SIGNATURE _____ *DATE _____

EMPLOYEE MUST HAVE HEALTH CARE PROVIDER COMPLETE AND SIGN THIS SECTION FOR EST ONLY WHEN THE EMPLOYEE'S ABSENCE REQUIRES WRITTEN DOCUMENTATION

Instructions to Employee: Massachusetts Earned Sick Time Law permits the MBTA to require that you **timely submit written documentation signed by a health care provider indicating the need for the EST you have taken**, as verified on this form, when your use of EST (a) exceeds 24 consecutively scheduled work hours; (b) exceeds three consecutive days on which you were scheduled to work, (c) occurs within two weeks before your final scheduled day of work, (d) occurs after four foreseeable and undocumented absences within a three-month period, or (e) occurs during severe weather events or other emergencies.

After completing the first two sections of this form concerning EST, print your name here, _____, and list the date(s) for which you are seeking EST here _____, then give this form to your (or your family member's) health care provider to complete and sign.

Instructions to the Health Care Provider: The employee listed here has requested earned sick time under the Massachusetts Earned Sick Time law. Please answer all applicable questions below and be sure to sign the form. Please do not include the nature of the illness or any details of domestic violence.

Provider's name and business address: _____

Type of practice/Medical specialty: _____ **Telephone:(__)** _____ **Fax:(__)** _____

1. Is the employee listed here your patient? **YES ☐ NO ☐**
2. If the employee listed here is not your patient, is your patient the employee's child, spouse, parent, or parent of the employee's spouse? **YES ☐ NO ☐**
3. Did your patient suffer from a physical or mental illness, injury, or medical condition that required home care, professional medical diagnosis or care, or preventative medical care on the date(s) listed above? **YES ☐ NO ☐**
4. If the employee listed here is not your patient, did your patient suffer from a physical or mental illness, injury, or medical condition that required home care, professional medical diagnosis or care, or preventative medical care that required care by the employee listed here on the date(s) listed above? **YES ☐ NO ☐**
5. Did your patient have a routine medical appointment on the date(s) listed above, and did the employee listed here attend that appointment? **YES ☐ NO ☐**
6. Did the employee listed here have to travel to or from an appointment he or she had with you on the date(s) listed above? **YES ☐ NO ☐**
7. Did the employee listed here have to travel to or from a pharmacy on the date(s) listed above? **YES ☐ NO ☐**
8. Did the employee listed here have to travel to or from another location related to the care of your patient on the date(s) listed above? **YES ☐ NO ☐**

_____ _____
Signature of Health Care Provider **Date**