PER 19-1
Updated 8/5/15

MASSACHUSETTS BAY TRANSPORTATION AUTHORITY
STATEMENT OF CLAIM FOR SICK LEAVE ALLOWANCE

THIS SECTION TO BE COMPLETED AND SIGNED BY EMPLOYEE

*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

SELECTIONS BY EMPLOYEE FOR SICK PAY [MAKE SELECTIONS in **Box 1** OR **Box 2**, NOT BOTH]

An employee must have 5 years service with the Authority to qualify for the following: **Box 1**

☐ **I WISH TO USE 1ST DAY SICK PAY**

☐ **I WISH TO USE MY ONE OCCASION ABSENCE WITHOUT MEDICAL DOCUMENTATION**
(**NOTE:** Per CBA, you may also need to request 1st Day Sick Pay if you wish to be paid from the first day of this absence)

If CBA provides for SPP, the employee must have 5 years service and be attendance-related discipline free for the previous 24 months to qualify: **Box 2**

☐ **I WISH TO USE SICK PAID/PROTECTED DAY(S) (SPP) WITHOUT MEDICAL DOCUMENTATION.**
(If requesting this, employee must complete the entire top half of this form including employee signature.)

☐ **I WISH TO USE SICK PAID/PROTECTED DAY(S) (SPP) WITH MEDICAL DOCUMENTATION PER CBA.**
(If requesting this, employee must complete the entire top half of this form AND Attending Physician must complete and sign bottom half.)

*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

When this form is completed 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 _____

SECTION BELOW TO BE COMPLETED AND SIGNED BY ATTENDING PHYSICIAN ONLY

*THIS IS TO CERTIFY THAT _____
* NAME OF PATIENT

*HAS BEEN UNABLE TO WORK FROM _____
*ABSENCE BEGIN 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 _____
*FOLLOW-UP APPOINTMENT DATE - NO VAGUE TERMS ACCEPTED

*NATURE OF ILLNESS/DIAGNOSIS _____

*PROGNOSIS _____

*TREATMENT _____

*IF HOSPITALIZED, NAME OF HOSPITAL _____

*DATE/TIME ADMITTED: _____ *IS SURGERY/PROCEDURE REQUIRED OR ELECTIVE? _____

*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 *DATE

_____
*PHYSICIAN'S NAME (PLEASE PRINT)

_____
*NUMBER *STREET *CITY * STATE *ZIP

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