Short Term Disability Form

HR-BEN-066

Section 1 - Information and Instructions

The purpose of this form is to apply for short term disability benefits. The hospital and/or Physician responsible for treating the patient must complete the reverse side of this form.

Please fax a signed copy of the form to 212-852-8700 or e-mail a signed copy of the form to bscservice@mtabsc.org.

If you have any questions, please contact MTA Business Service Center (BSC) at 646-376-0123 or bscservice@mtabsc.org.

Section 2 - Employee Information

Print Name	Last		First	M.I. Suffix	BSC ID
Agency (check one)	☐ BSC	☐ B&T	☐ CC	☐ HQ Civilian	☐ HQ Police	Department
	☐ LI Bus	☐ LIRR	☐ MNR	☐ MTA Bus	☐ NYCT	
Street Address						
City					State	Zip Code
Phone (H)			Phone (W)			E-mail
Employee's Supervisor / Dept. Head					Supervisor's Phone	

Section 3 - Illness / Injury Information

Illness / Injury Date	Occupation-Based Illness / Injury ☐ Yes ☐ No
Report Type ☐ Initial ☐ Follow-up/Interim ☐ Other (Explain)	
Location Where Injury Occurred	

Section 4 - Other Benefits Employee is Receiving

Check all that apply.

☐ None	
☐ Worker's Compensation	Dates (from/to)
☐ Personal Injury Damages	Dates (from/to)
☐ Federal SSA Disability Benefits	Dates (from/to)
☐ Railroad Retirement	Dates (from/to)
☐ Other (Provide Dates)	Dates (from/to)
Indicate any Short-Term Disability benefits previously received from other MTA Agencies	

Section 5 - Authorization

Employee Signature	Date	SSN Last 4 Digits
Signature of Person Other Than Employee	Date	
Print Name and Relationship		

Physician must complete this section

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Section 6 - Hospital Certification (if applicable)	
Hospital Name	Main Phone Number
Hospital Address Street City State Zip	
Description of Treatment / Surgical Procedure ☐ Additional Information Attached	
Hospital Stay Admittance Date Discharge Date	
Name of Hospital Official	Title of Hospital Official
Signature of Hospital Official	Date

Section 7 - Physician's Certification	
Physician's Name	Phone Number
Physician's Address Street: City: State: Zip:	
Period of Treatment From date(s) To date(s)	
First date unable to work Date suitable to return to work	Work-related condition? ☐ Yes ☐ No
Employee may return to work as follows (Check all that apply) ☐ Full-time ☐ Part-time ☐ Temporarily (provide details) ☐ Full duty ☐ Light duty	
Description of condition, diagnosis or treatment ☐ Additional Information Attached Date(s) of future treatment(s) Physician's Signature Date	Physician's tax I.D. number *Physician's Seal must be placed here.*