Employee Services
2301 Lou Menk Dr. BLDG: GOB-3E
Fort Worth, TX 76131-2828
Fax: 817-352-3852

CERTIFICATION OF HEALTH CARE PROVIDER
Medical Leave of Absence

This form is for non-FMLA eligible, scheduled employees ONLY to request a continuous Medical Leave of Absence because of their own health condition. This form is NOT intended for: (1) exempt employees; (2) scheduled employees who qualify for FMLA leave; or (3) scheduled employees who need time off intermittently or to care for a sick family member.

PART A: EMPLOYEE INFORMATION (*Employee completes this section*)

Employee's Name:_____ BNSF ID#: _____

Employee's Preferred Email Address: _____ Division: _____

☐ Request for New MLOA Leave ☐ Request for Extension of an Existing MLOA Leave

NEW LEAVES: THIS FORM IS DUE WITHIN 15 CALENDAR DAYS OF THE COMPLETION OF YOUR NOTICE OF INTENT TO TAKE LEAVE

LEAVE EXTENSIONS: THIS FORM IS DUE PRIOR TO YOUR LEAVE EXPIRATION DATE

PART B: MEDICAL FACTS (*Doctor or treating health care provider completes remaining questions*)

1. Describe the medical facts regarding the condition for which leave is requested. The medical facts must be sufficient to support the need for leave. **Include actual diagnosis, Diagnosis Code, symptoms, procedure type and date, any regimen of continuing treatment (such as the use of specialized equipment), and any other relevant medical facts**:

_____

_____

_____

2. State the approximate dates needed for the employee's continuous leave of absence:

Beginning date: ____/____/_____ Estimated end date: ____/____/_____

3. Was the employee admitted for an **overnight stay** in a hospital or residential medical care facility? ☐ YES ☐ NO

If **YES**, please list the date(s) of admission and release: ____/____/_____ - ____/____/_____

4. List date employee started treatment for this health condition and future scheduled appointments**:**

Treatment start date: ____/____/_____ Next scheduled appointment date: ____/____/_____

5. Is the medical condition **pregnancy**? ☐ YES ☐ NO If **YES**, expected delivery date: ____/____/_____

6. Please provide a description of the employee's **treatment**, if any (*e.g.*, prescription drugs or physical therapy requiring special equipment):

_____

_____

_____

7. If any treatment will be provided by a **provider of health services other than you** (*e.g.*, a physical therapist), please state the nature of the treatments, including duration, frequency, provider's specialty, etc.:

_____

_____

8. Will the employee be unable to perform all or a portion of their **job functions** or duties because of their condition upon return from leave? ☐ YES ☐ NO

If **YES**, please specify any **restriction(s)** and identify the likely **duration** of the employee's inability to perform such job functions or duties. (e.g., weightlifting restriction, a physical movement restriction, etc.)

_____

_____

9. Is the employee at risk of **sudden incapacitation**? (e.g., sudden loss of consciousness or cognitive function, sudden loss of hearing or vision, seizures, etc.) ☐ YES ☐ NO

If **YES**, please specify the possible incapacitation and estimated duration of the incapacitation:

_____

_____

10. Describe any **other relevant medical facts** related to the employee's condition and need for a leave of absence:

_____

_____

PART C: DOCTOR OR TREATING HEALTH CARE PROVIDER INFO

_____
Doctor or Treating Provider's NPI #

_____ _____
Printed Name and Degree of Health Care Provider *X* *Signature* *Date*

_____ _____
Type of Practice *Telephone* *Fax*

_____ _____
Address *City* *State* *Zip Code*

The Genetic Information Nondiscrimination Act of 2008 (GINA) prohibits employers and other entities covered by GINA Title II from requesting or requiring genetic information of an individual or family member of the individual, except as specifically allowed by this law. To comply with this law, we are asking that you not provide any genetic information when responding to this request for medical information. "Genetic information" includes an individual's family medical history, the results of an individual's or family member's genetic tests, the fact that an individual or an individual's family member sought or received genetic services, and genetic information of a fetus carried by an individual or an individual's family member or an embryo lawfully held by an individual or family member receiving assistive reproductive services.

Please fax or email this form directly from your office before returning to the employee:

BNSF Railway Employee Services Secure Fax Number: (817) 352-3852

Email: EmployeeServicesMLOA@bnsf.com