Short-Term Disability (STD) Form
Non-Represented/Management

HR-BEN-066

Section 1 - Information and Instructions

The purpose of this form is to apply for short term disability benefits if you are a **Non-Represented/ Managerial employee (for NYCT Managerial employees only)**. Please complete section s 2, 3 and 4 of this form. Your treating physician is responsible for completing section 5.

Please fax a signed copy of Page 1 of this form to 212-852-8700 or email a signed copy to bscservice@mtabsc.org. Please send Page 2 (section 5) of this form to your agency medical department.

If you have any questions, please contact the 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/Dept. (check one)	☐ BSC	☐ B&T	☐ CC	☐ HQ	☐ Police	Department
	☐ SIR	☐ LIRR	☐ MNR	☐ MTA Bus	☐ NYCT	
					☐ MaBSTOA	
Street Address						
City					State	Zip Code
Phone (H)		Phone (W)				Email

Section 3 – Other Benefits Employee is Receiving

Check all that apply.

☐ None	
☐ Worker's Compensation	Dates (from/to)
☐ Personal Injury	Dates (from/to)
☐ Federal SSA Disability Benefits	Dates (from/to)
☐ Railroad Retirement	Dates (from/to)
☐ Other (Provide Dates)	Dates (from/to)

Section 4 - Authorization

I understand that fraudulently requesting, obtaining and/ or misusing leave will be cause for disciplinary actions, up to and including dissmisal from employment.

Employee Signature	Date

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Section 5 – Physician's Certification TO BE COMPLETED BY YOUR PHYSICIAN

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 Work-related condition ? ☐ Yes ☐ No

Employee anticipated date of Return: ___________________________
(Even if considerable question exists, estimate date. Avoid use of terms such as "unknown" or "undetermined".)

Diagnosis Code : ____________________

Description of condition, diagnosis and treatment:

☐ Additional Information Attached

a. Date of first treatment: ___________________________
b. Date of most recent treatment: ___________________________
c. Date(s) of future treatment(s) : __________

Physician's Signature:____ Date:_____________________

Physician's tax I.D. number: ____

Type of Practice: ____