Print and Save functions are available by clicking anywhere on the form and hitting the F8 key on your keyboard.

Employee Medical Leave

Employee Name	**Union Code/Union**
Employee ID	**Job Title**
Employee Address	**Location**
	Division
City, State	**Department**
Zip code	**Supervisor**

Date of Leave: Begin Date: *Requested End Date:

Is this a New Leave or an Extension?

Note: The requested end date must be approved by your Supervisor or Leave Administrator (the end date may be altered during the approval process).

***Note to Employee:* Before submitting this form, you must click on the following link to print necessary forms and instructions for your subsequent return to work:** http://bnsfweb.bnsf.com/departments/hr/medical/pdf/RTW.pdf

Requirements for physician information to support your medical leave must be submitted to your supervisor or leave administrator. The physician statement must indicate that you are unable to perform service and include the estimated duration of your leave. The physician statement should **not** include any medical information. Click here to see craft specific highlights concerning your leave of absence: http://bnsfweb.bnsf.com/departments/laborrelations/html/loa.html

This requested leave of absence is not approved until you are advised as such by the approving officer.

You will be expected to mark up for duty by the end date approved by your supervisor or leave administrator. If for any reason you find you will be unable to report for duty, you must request a leave extension, providing your supervisor or leave administrator with **sufficient documentation from your physician to support a leave extension**. Request for extension must be made in time to permit action by the supervisor prior to the expiration of this leave.

Failure to report for duty on or before the date of the expiration of the leave of absence, unless application for extension has been approved, will be considered absent without authority and can be grounds for termination (for some crafts, failure to do so can result in automatic forfeiture of seniority).

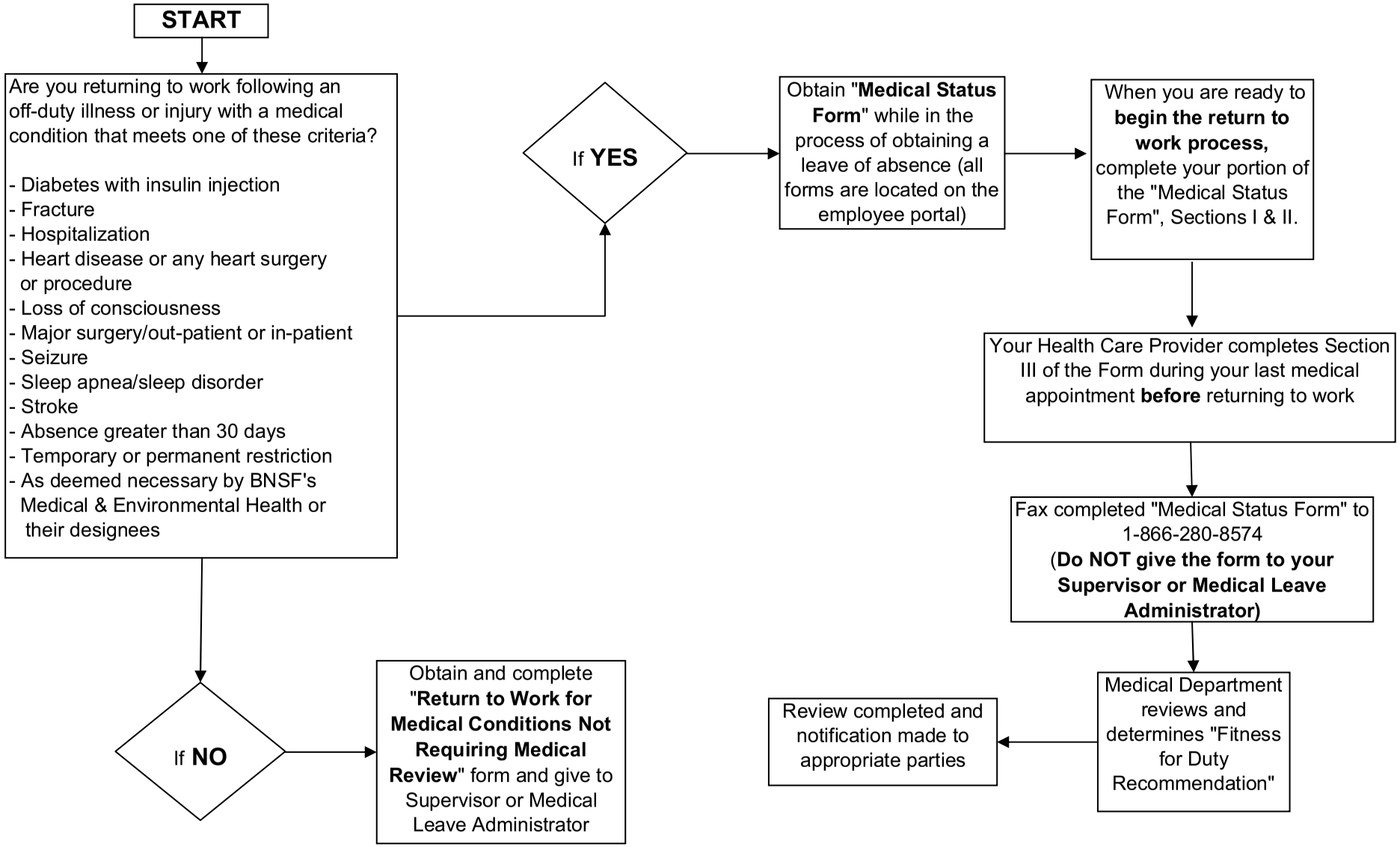
Engaging in outside employment or business during the term of this leave is not permitted unless special written authority is granted you to do so. Time on medical leave will count toward any unused FMLA leave.

Comments

Signature

Date

Return To Work Process for Off-Duty Illness or Off-Duty Injury



INSTRUCTIONS FOR COMPLETING MEDICAL STATUS FORM

This form must be filled out completely or it will impact the employee's work status. Be advised, the processing of these forms takes 3-5 days and should be submitted at least one week prior to return to work date.

SECTION I

BNSF Contact

1. Complete all items in Section I.
2. The Medical Status Form is to be used by the employee to return to work following a Medical Leave of Absence (MLOA). This form is not intended to be used for securing or extending MLOA.

SECTION II

Employee

1. Once your health care provider has advised you have been cleared to return to work, this form is required to be completed and submitted.
2. Complete all items in Section II, including your signature and date in the space provided.
3. Please ensure that your health care provider completes Section III of the form.

SECTION III

Health Care Provider (please read)

1. Please complete all items in Section III, including ***Work Status Recommendation***.
2. When requesting restricted duty, a **FULL DUTY** release date must also be included. The full duty date may be an estimate and is subject to change.
3. Employees will only be considered for our restricted duty **Transitional Work Program** if they meet BNSF program criteria based on type of condition and length of restrictions.
4. If this is a heart related condition, please mark the appropriate functional classification and objective assessment (refer to chart below).
5. Long-term **Restricted Activity** recommendations will need additional detailed objective medical evidence to support the restrictions, such as a valid Functional Capacity Evaluation and the 2 most recent office notes.
6. A recommendation of **Unable to Perform any Activity** does not require the completion of this form. In order for the employee to secure or extend medical leave of absence, a request must be submitted to their supervisor with a physician's note stating the employee is unable to perform any activity.
7. To maintain confidentiality, fax this form to 1-866-280-8574 (listed at the top and bottom of the form).

Thank you for your time and consideration.

American Heart Association Classifications

Functional Capacity	Objective Assessment
Class I – Patients with cardiac disease but without resulting limitation of physical activity. Ordinary physical activity does not cause undue fatigue, palpitation, dyspnea, or anginal pain.	A. No objective evidence or cardiovascular disease.
Class II – Patients with cardiac disease resulting in slight limitation of physical activity. They are comfortable at rest. Ordinary physical activity results in fatigue, palpitation, dyspnea, or anginal pain.	B. Objective evidence of minimal cardiovascular disease.
Class III – Patients with cardiac disease resulting in marked limitation of physical activity. They are comfortable at rest. Less than ordinary activity causes fatigue, palpitation, dyspnea, or anginal pain.	C. Objective evidence of moderately severe cardiovascular disease.
Class IV – Patients with cardiac disease resulting in inability to carry on any physical activity without discomfort. Symptoms of heart failure or the anginal syndrome may be present even at rest. If any physical activity is undertaken, discomfort is increased.	D. Objective evidence of severe cardiovascular disease.

MEDICAL STATUS FORM for Non Work Related Medical Conditions

Fax completed form to 1-866-280-8574

Questions? Please call the BNSF Off-Duty Department at 1-800-992-5531, Ext. 7310, Patti Cunliffe, R.N.

SECTION I – BNSF CONTACT

BNSF Contact and Title: _____

Telephone: _____ Fax: _____ Division: _____

SECTION II - EMPLOYEE (all items must be completed, please see instructions)

Name:	Employee ID or SSN:	Date of Birth:
Address:	Home Telephone:	Last Day Worked:
	Job Title:	Current BNSF issued DOT CMV Certificate Holder? ☐ Yes ☐ NO / Department:

List all medications that you are taking regularly (including over the counter medications):

Treating Physician's Name: _____

Address: _____ Telephone: _____

City, State, Zip: _____ Fax: _____

I hereby authorize my physician to release any information that is requested with respect to this medical condition to the BNSF Medical & Environmental Health Department and/or their designees.

Employee's Signature: _____ ***Date:*** _____

SECTION III - HEALTH CARE PROVIDER (all items must be completed, please see instructions)

Diagnosis:	ICD Codes:
Current Objective Findings and Response to Treatment:	
Did patient require surgery? ☐ Yes ☐ NO	Type and date of surgery:
Medication(s) Prescribed – Dosage & Frequency:	Is the employee's agility and/or mental alertness impaired by a medical condition or medication(s)? ☐ Yes ☐ NO
	FOR HEART DISEASE ONLY (please see instructions) American Heart Association Functional Classification (circle): I II III IV American Heart Association Objective Assessment (circle): A B C D

*** * * * * * * * * Work Status Recommendation * * * * * * * * ***

☐ **Full Duty** (***No Restrictions***) **Effective Date:** _____

☐ **Restrictive Activity** ***(Complete below)*** **Effective Date:** _____

Planned Full Duty Date: _____ ***or*** **Next Follow-up Date**: _____

Circle applicable activity level
N = No activity
O = Occasional
F = Frequent

Walking on uneven surfaces:	N	O	F	Climbing (ladder, scaffold, etc):	N	O	F
Stooping, bending or twisting:	N	O	F	Working on unprotected heights:	N	O	F
Operating vehicles or machinery:	N	O	F	Lifting up to _____ lbs:	N	O	F
Other: _____					N	O	F
Other: _____					N	O	F

These restrictions are: ☐ Temporary ☐ Long-Term (*Please send 2 most recent office notes*)

Unable To Perform Any Activity determination does not require the completion of this form. BNSF employees secure medical leave of absences by submitting a request to their supervisor with a physician's note stating the employee is unable to perform any activity.

Health Care Provider's Signature: _____ ***Date Completed:*** _____

FAX completed form to 1-866-280-8574

Return to Work for Medical Conditions <u>Not</u> Requiring Medical Review

I, _____, acknowledge that I can safely return to my
(printed name of employee)

regular job following an absence from work of less than 30 days due to an off duty/off property injury/illness. I do not require transitional work as I do not have work place restrictions that prevent me from safely performing my regular duties. I also acknowledge that my injury/illness is **NOT** one of the following conditions:

- Diabetes with insulin injection
- Fracture
- Hospitalization
- Heart disease or any heart surgery or procedure
- Loss of consciousness
- Major surgery (out-patient or in-patient)
- Seizure
- Sleep apnea/sleep disorder
- Stroke
- Absence greater than 30 days
- Temporary or permanent restrictions
- On-the-job injury
- BNSF's Medical & Environmental Health (or their designee) has not required further medical evaluation of my condition

_____ _____
Employee Signature Date

Employee ID: _____

<u>Instructions to Employee</u>: Please complete the form and return to your medical leave administrator or your supervisor (generally whoever processed your original leave).

<u>Instructions to Medical Leave Administrator or Supervisor</u>: Upon receipt of this signed form, please fax to Personnel Records at 817-352-0970 and mail the original to Personnel Records, 2400 Western Center Blvd., Ft. Worth, Texas, 76131