CERTIFICATION FOR SERIOUS INJURY OR ILLNESS OF COVERED SERVICEMEMBER: MILITARY FAMILYLEAVE - FAMILY AND MEDICAL LEAVE ACT

SECTION I: For Completion by Employee and/or Covered Servicemember for Whom the Employee Is Requesting Leave:

This section must be completed before any of the below sections can be completed by a health care provider.

The Family and Medical Leave Act ("FMLA") permits an employer to require that an employee submit a timely, complete, and sufficient certification to support a request for FMLA leave due to a serious injury or illness of a covered servicemember. If requested by the employer, your response is required to obtain or retain the benefit of FMLA-protected leave. Failure to do so may result in a denial or delay of your FMLA request or non-designation of your leave as FMLA leave. You must be given at least 15 calendar days to return this form to your employer.

Part A: Employee Information

Name and address of the employer (this is the employer of the employee requesting leave to care for a covered servicemember): _____

_____

Name of employee requesting leave to care for a covered servicemember:

_____

[First] [Middle] [Last]

Name of the covered servicemember (for whom employee is requesting leave to care):

_____

[First] [Middle] [Last]

Relationship of employee to covered servicemember for whom employee will be providing care:

☐ Spouse ☐ Parent ☐ Son Daughter ☐ Next of Kin ☐ Other (Please specify relationship)

_____

Part B: Covered Servicemember Information

1. Is the covered servicemember a current member of the regular Armed Forces, the National Guard or Reserves? ☐ Yes ☐ No

If yes, please provide the covered servicemember's military branch, rank, and unit to which the servicemember is currently assigned:

_____

2. Is the covered servicemember a veteran of the Armed Forces, National Guard, or Reserves? ☐ Yes ☐ No

If yes, please provide the covered servicemember's last military branch, rank and unit assigned to:

_____

3. Is the covered servicemember assigned to a military medical treatment facility as an outpatient or to a unit established for the purpose of providing command and control of members of the Armed Forces receiving medical care as outpatients (such as a medical hold or warrior transition unit)? ☐ Yes ☐ No

If *yes,* please provide the name of the medical treatment facility or unit:

_____

4. Is the covered servicemember on the Temporary Disability Retired List (TDR)? ☐ Yes ☐ No

Part C: <u>Care to Be Provided to the Covered Servicemember</u>

Describe the care to be provided to the covered servicemember and an estimate of the leave needed to provide the care:

_____

_____

SECTION II: For completion by a United States Department of Defense ("DOD") health care provider or a health care provider who is either: (1) a United States Department of Veterans Affairs ("VA") health care provider; (2) DOD TRICARE Network authorized private health care provider; or (3) a DOD Non-Network TRICARE authorized private health care provider. If you are unable to make certain of the military-related determinations contained below in Part B, you are permitted to rely upon determinations from an authorized DOD representative (such as a DOD Recovery Care Coordinator). (Please ensure that Section I above has been completed before completing this section.) Please be sure to sign the form on the last page. The employee listed on the previous page has requested leave under the FMLA to care for a family member who is either (1) a current member of the Regular Armed Forces, the National Guard, or the Reserves who is undergoing medical treatment, recuperation, or therapy, is otherwise in outpatient status, or is otherwise on the temporary disability retired list for a serious injury or illness, or (2) a veteran who is undergoing medical treatment, recuperation, or therapy, for a serious injury or illness and who was a member of the Armed Forces (including a member of the National Guard or Reserves) within five years preceding the date on which the veteran undergoes treatment, recuperation or therapy. For current members of the Regular Armed Forces, the National Guard or Reserves, a "serious injury or illness" is one that was incurred in the line of duty on active duty (or existed before the beginning of the member's active duty and was aggravated by service in the line of duty) that may render the servicemember medically unfit to perform the duties of his or her office, grade, rank, or rating. For veterans identified above, a "serious injury or illness" means a qualifying (as defined by the Secretary of Labor) injury or illness that was incurred by the member in the line of duty on active duty in the Armed Forces or existed before the beginning of the member's active duty and is:

(i) A continuation of a serious injury or illness that was incurred or aggravated by service in the line of duty on active duty and that manifested itself before or after the member became a veteran.

(ii) A physical or mental condition for which the covered veteran has received a U.S. Department of Veterans Affairs Service Related Disability Rating (VASRD) of 50 percent or greater, and such VASRD rating is based, in whole or in part, on the condition precipitating the need for military caregiver leave or

(iii) A physical or mental condition that substantially impairs the covered veteran's ability to secure or follow a substantially gainful occupation by reason of a disability or disabilities related to military service, or would do so absent treatment; or

(iv) An injury, including a psychological injury, on the basis of which the covered veteran has been enrolled in the Department of Veterans' Affairs Program of Comprehensive Assistance for Family Caregivers.

A complete and sufficient certification to support a request for FMLA leave due to a covered servicemember's serious injury or illness includes written documentation confirming that the covered servicemember's injury or illness was incurred in the line of duty on active duty and that the covered servicemember is undergoing treatment for such injury or illness by a health care provider listed above. Please answer all applicable parts fully and completely. Several questions seek a response as to the frequency or duration of a condition, treatment, etc. Your answer should be your best estimate based upon your medical knowledge, experience, and examination of the patient. Be as specific as you can; terms such as "lifetime," "unknown," or "indeterminate" may not be sufficient to determine FMLA coverage. Limit your responses to the condition for which the employee is seeking leave. Do not provide information about genetic tests or genetic services.

Part A: <u>Health Care Provider Information</u>

Health care provider's name and business address: _____

_____

Type of practice/medical specialty:_____

_____

Please state whether you are either: (1) a DOD health care provider; (2) a VA health care provider; (3) a DOD TRICARE network authorized private health care provider; or (4) a DOD non-network TRICARE authorized private health care provider:

Type of Provider:_____

Telephone:_____ Fax:_____ Email:_____

PART B: <u>Medical Status</u>

1. The covered servicemember's medical condition is classified as (check one of the following):

☐ **(VSI) Very Seriously Ill/Injured -** Illness/Injury is of such a severity that life is imminently endangered. Family members are requested at bedside immediately. (Please note this is an internal DOD casualty assistance designation used by DOD healthcare providers.)

☐ **(SI) Seriously Ill/Injured -** Illness/injury is of such severity that there is cause for immediate concern, but there is no imminent danger to life. Family members are requested at bedside. (Please note this is an internal DOD casualty assistance designation used by DOD healthcare providers.)

☐ **Other Ill/Injured -** a serious injury or illness that may render the servicemember medically unfit to perform the duties of the member's office, grade, rank, or rating.

☐ **None of the Above** (Note to employee: If this box is checked, you may still be eligible to take leave to care for a covered family member with a "serious health condition." If such leave is requested, you may be required to complete a health care provider certification form.)

2. Was the condition for which the covered servicemember is being treated incurred in the line of duty on active duty in the Armed Forces? ☐ Yes ☐ No

3. Did the condition exist before the beginning of the member's active duty and become aggravated by service in the line of duty on Active Duty in the Armed Forces? ☐ Yes ☐ No

4. Approximate date condition commenced:_____

5. Probable duration of condition and/or need for care: _____

6. Is the covered servicemember undergoing medical treatment, recuperation, or therapy? ☐ Yes ☐ No

If "yes," and the servicember is a veteran, what is (are) the date(s) on which the veteran commenced and is undergoing medical treatment, recuperation, or therapy?

_____

PART C: <u>Covered Servicemember's Need for Care by Family Member</u>

"Need for care" encompasses both physical and psychological care. It includes situations where, for example, due to his or her serious injury or illness, the veteran is unable to care for his or her own basic medical, hygienic, or nutritional needs or safety, or is unable to transport him or herself to the doctor. It also includes providing psychological comfort and reassurance which would be beneficial to the veteran who is receiving inpatient or home care.

1. Will the covered servicemember need care for a single continuous period of time, including any time for treatment recovery? ☐ Yes ☐ No

If *yes,* estimate the beginning and ending dates for this period of time:_____

2. Will the covered servicemember require periodic follow-up treatment appointments? ☐ Yes ☐ No

If yes, estimate the treatment schedule:

_____

3. Is there a medical necessity for the covered servicemember to have periodic care for these follow-up treatment appointments? ☐ Yes ☐ No

Is there a medical necessity for the covered servicemember to have periodic care other than scheduled follow-up treatment appointments (e.g., episodic flare-ups of medical condition)?
☐ Yes ☐ No

If *yes,* please estimate the frequency and duration of the periodic care:

_____

_____

_____

Signature of Health Care Provider: _____ *Date:* _____