CERTIFICATION FOR SERIOUS INJURY OR ILLNESS OF COVERED SERVICE MEMBER FOR MILITARY FAMILY LEAVE (FMLA) [Fillable version (fill out on computer)]

Section One

INSTRUCTIONS to the EMPLOYEE: Please complete Section One before having Section Two completed. The 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 service member. The completion of the paperwork is necessary to obtain or retain the benefit of FMLA-protected leave. [29 U.S.C.§§ 2613, 2614(c)(3)]. Failure to do so may result in a denial of your FMLA request. [29 C.F.R. § 825.310(f)]. You have 15 calendar days to return this form. This section must be completed first before any of the below sections canbe completed by a health care provider.

Part A: Employee Information

Your name: _____
First Middle Last Employee ID (SHARE ID)

Name of covered service member for whom you will provide care: _____
First Middle Last

Your relationship to covered service member for whom you will provide care: ☐ Spouse ☐ Parent ☐ Son ☐ Daughter ☐ Next of kin

Part B: Covered Service Member Information

1. Is the Covered Service member a current member of the regular armed forces, the National Guard or Reserves? No ☐ Yes ☐
If **YES**, , please provide the covered service member's current military . . . branch _____, rank _____, and unit _____.

Is the covered service member assigned to a military medical treatment facility as an outpatient or assigned 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)? No ☐ Yes ☐

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

2. Is the covered service member on the Temporary Disability Retired List (TDRL)? No ☐ Yes ☐

3. Describe the care you will provide to the covered service member and estimate the amount of leave needed to provide that care:

_____

Section Two

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) a DOD TRICARE network authorized private health care provider; or (3) a DOD non-network TRICARE authorized private health care provider. The employee listed on Page 1 has requested leave under the FMLA to care for a family member who is a 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. For purposes of FMLA leave, a serious injury or illness is one that was incurred in the line of duty on active duty that may render the service member medically unfit to perform the duties of his or her office, grade, rank, or rating.

A complete and sufficient certification to support a request for FMLA leave due to a covered service member's serious injury or illness includes written documentation confirming that the covered service member's injury or illness was incurred in the line of duty on active duty and that the covered service member is undergoing treatment for such injury or illness by a health care provider listed above. Answer, fully and completely, all applicable parts. 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.

If you are unable to make certain of the military-related determinations contained below in Part A and 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 and date the form on the last page.

Provider's name (please print): _____ Type of practice/medical specialty: _____

Provider's business address: _____

Please indicate if you are: ☐ a DOD health care provider; ☐ a VA health care provider; ☐ a DOD TRICARE network authorized private health care provider; or ☐ a DOD non-network TRICARE authorized private health care provider.

Telephone: _____ Fax: _____

Part A: Medical Facts

1. Covered Service member's medical condition is classified as (check one box):

(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 service member 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" under § 825.113 of the FMLA.
(If such leave is requested, you may be required to complete DOL FORM WH-380 or an employer-provided form seeking the same information.)

2. Was the condition for which the covered service member is being treated incurred in the line of duty while on active duty in the armed forces? No ☐ Yes ☐

3. Approximate date condition commenced: _____

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

5. Is the covered service member undergoing medical treatment, recuperation, or therapy? No ☐ Yes ☐

If **YES**, please describe medical treatment, recuperation or therapy:

Part B: Covered Service Member's Need for Care by Family Member

1. Will the covered service member need care for a single continuous period of time due to their medical condition, including any time for treatment and recovery? No ☐ Yes ☐

If **YES**, estimate the beginning and ending dates for the period of care: _____

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

If **YES**, estimate treatment schedule, if any, including:

Date of Appointment	Time Required	Recovery Period

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

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

If YES, ***estimate*** the ***approximate*** frequency and duration of needed periodic care (e.g., 1 episode every 3 months lasting 1-2 days):

Frequency: _____ time per week or _____ per month

Duration: _____ hour(s) or _____ day(s) per episode

Additional Information: Identify question number with your additional answer.

Print name of Health Care Provider: _____

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

This Form MUST be signed and dated by hand, NOT digitally.