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CERTIFICATION FOR SERIOUS INJURY OR ILLNESS OF COVERED SERVICEMEMBER FOR MILITARY LEAVE (FAMILY AND MEDICAL LEAVE ACT)

SECTION I: For Completion by the EMPLOYEE and/or the COVERED SERVICEMEMBER for whom the Employee Is Requesting Leave:

INSTRUCTIONS to the EMPLOYEE or COVERED SERVICEMEMBER: Please complete Section I before having Section II completed. The FMLA permits an employer to require that an employee submit a timely, complete, and sufficient certification to support a request for FMLA 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 an employee's FMLA request. 29 C.F.R. § 825.310(f). You must return this form completed to Human Resources within 15 days.

SECTION 1: For completion by the EMPLOYEE and/or the COVERED SERVICEMEMBER for whom the Employee Is Requesting Leave: (This section must be completed first before any of the below sections can be completed by a health care provider)

PART A: EMPLOYEE INFORMATION

Name of Employee Requesting Leave to Care for Covered Servicemember:

_____
First Middle Last

Employee Number _____

Department_____

Name of Covered Servicemember (person who will be cared for by Employee):

_____

Relationship of Employee to Covered Servicemember Requesting Leave to Care:

Spouse_____ Parent_____ Son_____ Daughter_____ Next of Kin (Specify)_____

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 current assignment:

Military Branch_____ Rank_____ Unit_____

(2) 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:

_____

(3) Is the Covered Servicemember on the Temporary Disability Retired List (TDRL)?

_____Yes _____No

PART C: CARE TO BE PROVIDED TO THE COVERED SERVICEMEMBER

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) a DOD TRICARE network authorized private health care provider; or

(3) a DOD non-network TRICARE authorized private health care provider

INSTRUCTIONS to the HEALTH CARE PROVIDER: The employee listed on Page 2 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 servicemember 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 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 OF THE FOLLOWING QUESTIONS COMPLETELY AND FULLY. 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 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.**

Part A: HEALTH CARE PROVIDER NFORMATION

Health Care Provider's Name and Business Address:

Name_____

Address_____

_____

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:

_____

Part B: MEDICAL STATUS

(1) Covered Servicemember's medical condition is classified as (Check One of the Appropriate Boxes):

_____**(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" under Section 825.113 of the FMLA. If such leave is requested, you may be required to complete a separate form in connection with this request)

(2) Was the condition for which the Covered Service member is being treated incurred in line of duty on active duty in the armed forces? _____Yes _____No

(3) Approximate date condition commenced:_____

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

(5) Is the covered servicemember undergoing medical treatment, recuperation, or therapy? _____Yes _____No.

(6) If yes, please describe medical treatment, recuperation or therapy:

_____

_____

PART C: COVERED SERVICEMEMBER'S NEED FOR CARE BY FAMILY MEMBER

(1) Will the covered servicemember need care for a single continuous period of time, including any time for treatment and recovery? _____Yes _____No

(2) Will the covered servicemember require periodic follow-up treatment appointments?

_____Yes _____No

(2) 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

(4) Is there a medical necessity for the covered servicemember to have periodic care for other than scheduled follow-up treatment appointments (e.g., episodic flare-ups of medical condition)? _____Yes _____No

(5) If yes, please estimate the frequency and duration of the periodic care:

_____

_____

SIGNATURE OF HEALTH CARE PROVIDER

_____

DATE_____