Certification of Serious Illness or Injury of Covered Service Member (Family and Medical Leave Act)

SECTION I: For Completion by the EMPLOYEE

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 leave due to a serious injury or illness of a covered service member. 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 of an employee's FMLA request. The employer must give an employee at least 15 calendar days to return this form to the employer.

Part A: Employee Information

Employee Name _____ Employee ID _____

Name and Address of Employer _____

Name of covered service member: _____

Relationship of covered service member to you: _____

Part B: Covered Service Member Information

Is the covered service member a current member of the Regular Armed Forces, the National Guard, or Reserves? ☐ Yes ☐ No

If yes, please provide the covered service member's military branch, rank, and current assigned unit:

_____

Is the covered service member 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

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

PART C: Care to be Provided to the Covered Service Member

Describe the care to be provided to the service member and estimate the amount of leave needed to provide the care:

_____

_____

_____

_____

_____

Retention Schedule: Upon completion, this form shall be retained permanently in the official and local medical file of the employee.

SECTION II: For Completion by the HEALTH CARE PROVIDER

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. 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 be sure to sign the form on the last page.

Part A: Health Care Provider Information

Name of Health Care Provider: _____

Type of Practice/Specialty: _____

Address: _____

Telephone: _____ Fax: _____

E-mail: _____

Please indicate whether you are either: ☐ 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.

Part B: Medical Status

Covered Service Member'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 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 a certification form seeking the same information.)

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

Approximate date condition commenced: _____

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

Is the covered service member undergoing medical treatment, recuperation, or therapy?

☐ Yes ☐ No If so, please describe: _____

_____

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

Will the covered service member need care for a single continuous period of time, including any time for treatment and recovery? ☐ Yes ☐ No

If so, please estimate the beginning and end dates for this period of time: _____

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

If so, please estimate the treatment schedule: _____

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

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

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

_____

_____

_____

_____ _____

Signature of Health Care Provider Date

Retention Schedule: Upon completion, this form shall be retained permanently in the official and local medical file of the employee.