FAMILY AND MEDICAL LEAVE
CERTIFICATION FOR SERIOUS INJURY OR ILLNESS OF VETERAN FOR MILITARY FAMILY LEAVE

SECTION I – FOR COMPLETION BY THE EMPLOYER

Employee Name: _____
First, Middle, Last

Employer name:_____Date:_____*(mm/dd/yyyy)*
(List date certification requested)

Contact Information: _____

The certification must be returned by_____(mm/dd/yyyy)
(Must allow at least 15 calendar days from the date requested, unless it is not feasible despite the employee's diligent, good faith efforts.)

SECTION II – FOR COMPLETION BY THE EMPLOYEE and/or VETERAN

INSTRUCTIONS to the EMPLOYEE or VETERAN: Please complete Section II before having Section III completed. The Family and Medical Leave Act (FMLA) provides that eligible employees may take FMLA leave to care for a covered veteran with a serious illness or injury. The FMLA allows an employer to require an employee seeking FMLA leave for this purpose to submit a medical certification. 29 U.S.C. §§ 2613, 2614(c)(3). The employer must give the employee **at least 15 calendar days** to provide the certification. If the employee fails to provide complete and sufficient certification, his or her FMLA leave request may be denied. 29 C.F.R. § 825.313.

PART A: EMPLOYEE INFORMATIOM

Name of the veteran for whom employee is requesting leave:

_____
First, Middle, Last

Select your relationship to the veteran. You are the veteran's:

☐ Spouse ☐ Parent ☐ Child ☐ Next of Kin

PART B: VETERAN INFORMATION AND CARE TO BE PROVIDED TO THE VETERAN

(1) The veteran was ☐ honorably ☐ dishonorably) discharged or released from the Armed Forces, including the National Guard or Reserves. List the date of the veteran's discharge:_____*(mm/dd/yyyy)*

(2) Please provide the veteran's military branch, rank and unit at the time of discharge: _____

_____

(3) The veteran (☐ is / ☐ is not) receiving medical treatment, recuperation, or therapy for an injury or illness.

(4) Briefly describe the care you will provide to the veteran: *(Check all that apply)*

☐ Assistance with basic medical, hygienic, nutritional, or safety needs ☐ Transportation
☐ Psychological Comfort ☐ Physical Care ☐ Other: _____

SECTION II CONTINUED – FOR COMPLETION BY THE EMPLOYEE and/or VETERAN

Employee Name: _____

(5) Give your **best estimate** of the amount of FMLA leave needed to provide the care described:

_____

(6) If a **reduced work schedule** is necessary to provide the care described, give your **best estimate** of the reduced work schedule you are able to work. From_____*(mm/dd/yyyy)* to_____*(mm/dd/yyyy)* I am able to work:_____*(hours per day)*_____*(days per week).*

SECTION III – HEALTH CARE PROVIDER

Please provide your contact information, complete all Parts of this Section fully and completely, and sign the form below. The employee named in Section I has requested leave under the military caregiver leave provision of the FMLA to care for a family member who is a veteran. A complete and sufficient certification to support a request for FMLA military caregiver leave due to a covered veteran's serious injury or illness includes written documentation confirming that the veteran's injury or illness was incurred in the line of duty on active duty or existed before the beginning of the veteran's active duty and was aggravated by service in the line of duty on active duty, and that the veteran is undergoing treatment, recuperation, or therapy for such injury or illness by a health care provider listed above.

PART A: HEALTH CARE PROVIDER INFORMATION

Health Care Provider's Name: *(Print)* _____

Health Care Provider's business address: _____

Type of Practice/Medical Specialty: _____

Telephone: (___)_____Fax: (___)_____E-mail: _____

Please select the type of FMLA health care provider you are:

- ☐ DOD health care provider
- ☐ VA health care provider
- ☐ DOD TRICARE network authorized private health care provider
- ☐ DOD non-network TRICARE authorized private health care provider
- ☐ Health care provider as defined in 29 CFR 825.125

PART B: MEDICAL INFORMATION

Please provide appropriate medical information of the patient as requested below. Limit your responses to the veteran's condition for which the employee is seeking leave. If you are unable to make certain military-related determinations contained below, you are permitted to rely upon determinations from an authorized DOD representative, such as a DOD Recovery Care Coordinator, or an authorized VA representative. Do not provide information about genetic tests, as defined in 29 C.F.R. § 1635.3(f), or genetic services, as defined in 29 C.F.R. § 1635.3(e).

(1) Patient's Name: _____

(2) List the approximate date condition started or will start:_____*(mm/dd/yyyy)*

(3) Provide your **best estimate** of how long the condition will last: _____

(4) The veteran's injury or illness: *(Select as appropriate)*

- ☐ Was incurred in the line of duty on active duty
- ☐ Existed before the beginning of the veteran's active duty and was aggravated by service in the line of duty on active duty
- ☐ None of the above

SECTION III CONTINUED – HEALTH CARE PROVIDER

Employee Name: _____

The veteran (☐ is / ☐ is not) undergoing medical treatment, recuperation, or therapy for this condition. If yes, briefly describe the medical treatment, recuperation, or therapy: _____

_____

(5) The veteran's medical condition is: *(Select as appropriate)*

☐ A continuation of a serious injury or illness that was incurred or aggravated when the covered veteran was a member of the Armed Forces and rendered the servicemember not able to perform the duties of the servicemember's office, grade, rank, or rating.

☐ 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% or higher, and such VASRD rating is based, in whole or in part, on the condition precipitating the need for military caregiver leave.

☐ 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.

☐ An injury, including a psychological injury, on the basis of which the covered veteran is enrolled in the Department of Veterans' Affairs Program of Comprehensive Assistance for Family Caregivers.

☐ 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 29 C.F.R. § 825.113 of the FMLA. If such leave is requested, you may be required to complete DOL FORM WH-380-F or an employer-provided form seeking the same information.*

Part C: Amount of Leave Needed

For the medical condition checked in Part B, complete all that apply. Some 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 military caregiver leave coverage.

(1) Due to the condition, the veteran will need care for a **continuous period of time**, including any time for treatment and recovery. Provide your **best estimate** of the beginning date_____*(mm/dd/yyyy)* and end date _____ *(mm/dd/yyyy)* for this period of time.

(2) Due to the condition, it is medically necessary for the veteran to attend **planned medical treatment** appointments (scheduled medical visits). Provide your **best estimate** of the duration of the treatment(s), including any period(s) of recovery
_____ *(e.g. 3 days/week)*

(3) Due to the condition, it is medically necessary for the veteran to receive care on an **intermittent basis** (periodically), such as the care needed because of episodic flare-ups of the condition or assisting with the veteran's recovery. Provide your **best estimate** of how often (frequency) and how long (duration) the episodes of incapacity will likely last.

Over the next 6 months, intermittent care is estimated to occur_____times per (☐ day / ☐ week / ☐ mnth) and are likely to last approximately_____(☐ hours / ☐ days) per episode.

Signature of Health Care Provider_____**Date** _____*(mm/dd/yyyy)*