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

SECTION I: FOR COMPLETION BY THE EMPLOYEE AND/OR THE CURRENT 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.)

INSTRUCTIONS to the EMPLOYEE or CURRENT 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 leave due to a serious injury or illness of a Servicemember. If requested by the employer, your response is required 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). The employer must give an employee at least 15 calendar days to return this form to the employer.

PART A: EMPLOYEE INFORMATION

Name and Address of Employer (this is the employer of the employee requesting leave to care for Current Servicemember):

Name of Employee requesting leave to care for Current Servicemember:

First, Middle, Last

Name of Current Servicemember (for whom employee is requesting leave to care):

First, Middle, Last

Relationship of Employee to Current Servicemember
☐ Spouse ☐ Parent ☐ Son ☐ Daughter ☐ Next of Kin

PART B: SERVICEMEMBER INFORMATION

1. Is the Servicemember a Current Member of the Regular Armed Forces, the National Guard, or Reserves?
   ☐ Yes ☐ No

   If yes, please provide the Servicemember's military branch, rank, and unit currently assigned to:

   Is the 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:

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

PART C: CARE TO BE PROVIDED TO THE SERVICEMEMBER

Describe the care to be provided to the Current 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; (3) a DOD non-network TRICARE authorized private health care provider; or (4) a health care provider as defined in 29 CFR 825.125. 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.

INSTRUCTIONS to the HEALTH CARE PROVIDER: The employee listed below has requested leave under the FMLA to care for a family member who is 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. For purposes of FMLA leave, a serious injury or illness is one that was incurred in the line of duty on active duty in the Armed Forces or that existed before the beginning of the member's active duty and was aggravated by service in the line of duty on active duty in the Armed Forces 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 Current Servicemember's serious injury or illness includes written documentation confirming that the Servicemember's injury or illness was incurred in the line of duty on active duty or if not, that the current servicemember's injury or illness existed before the beginning of the servicemember's active duty and was aggravated by service in the line of duty on active duty in the Armed Forces, and that the current Servicemember 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. 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(e).**

PART A: HEALTH CARE PROVIDER INFORMATION

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; (4) a DOD non-network TRICARE authorized private health care provider; or (5) a health care provider as defined in 29 CFR 825.125 :

Telephone: ( ) _____ Fax: ( ) _____ Email: _____

PART B: MEDICAL STATUS

1. Current 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 health care 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 that this is an internal DOD casualty assistance designation used by DOD health care 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 §825.113 of the FMLA. If such leave is requested, you may be required to complete County Auditor's Form 456B seeking the same information.)

2. Is the current Servicemember being treated for a condition which was incurred or aggravated by service in the 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 Servicemember undergoing medical treatment, recuperation, or therapy for this condition? ☐ Yes ☐ No. If yes, please describe medical treatment, recuperation, or therapy:

_____

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

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

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

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

   If yes, estimate the treatment schedule: _____

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

4. Is there a medical necessity for the Servicemember to have periodic care for 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**