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

SECTION I: FOR COMPLETION BY THE EMPLOYEE AND/OR THE VETERAN 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 VETERAN: 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 Veteran. 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 CFR § 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 a Veteran):

Name of Employee requesting leave to care for a Veteran:

First, Middle, Last

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

First, Middle, Last

Relationship of Employee to Veteran
☐ Spouse ☐ Parent ☐ Son ☐ Daughter ☐ Next of Kin (please specify relationship):

PART B: VETERAN INFORMATION

1. Date of Veteran's discharge: _____
2. Was the Veteran **dishonorably** discharged or released from the Armed Forces (including the National Guard or Reserves)?
   ☐ Yes ☐ No
3. Please provide the Veteran's military branch, rank, and unit at the time of discharge:
   _____
4. Is the Veteran receiving medical treatment, recuperation, or therapy for an injury or illness? ☐ Yes ☐ No

PART C: CARE TO BE PROVIDED TO THE VETERAN

Describe the care to be provided to the Veteran 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 Veteran. For purposes of FMLA military caregiver leave, a serious injury or illness means an injury or illness incurred by the Veteran in the line of duty on active duty in the Armed Forces (or that existed before the beginning of the Veteran's active duty and was aggravated by service in the line of duty on active duty in the Armed Forces) and manifested itself before or after the servicemember became a Veteran.

A complete and sufficient certification to support a request for FMLA 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 Veterans'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. 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 Veteran's condition for which the employee is seeking leave. Do not provide information about genetic tests, as defined in 29 CFR § 1635.3(f), or genetic services, as defined in 29 CFR § 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. Veteran's medical condition is classified as (check one of the appropriate boxes):

   ☐ 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 unable 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 percent or greater, 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 has been 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 § 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 Veteran 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 Veteran undergoing medical treatment, recuperation, or therapy for this condition? ☐ Yes ☐ No. If yes, please describe medical treatment, recuperation, or therapy:

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

1. Will the Veteran 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 Veteran require periodic follow-up treatment appointments? ☐ Yes ☐ No

   If yes, estimate the treatment schedule: _____

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

4. Is there a medical necessity for the Veteran 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**