Military Family Leave

(Certification for Serious Injury or Illness of Covered Service member for Military Family Leave)

Notice and instructions to the district:

The Family Medical Leave Act (FMLA) provides that a district may require an employee seeking FMLA leave due to a serious injury or illness of a covered service member to submit a certification providing sufficient facts to support the request for leave. Employees may not be asked to provide more information than allowed under the FMLA regulations. The district will maintain records and documents relating to medical certification, recertifications or medical histories of employees or employees' family member, created for FMLA purposes, as confidential medical records in separate files from personnel files and in accordance with 29 C.F.R. § 1630.14(c)(1), if the Americans with Disabilities Act applies.

Section 1

Part A: Employee information

Complete the employee and covered service member information below before giving this form to your family member or his/her medical provider.

____

District name and address

Name of employee requesting leave to care for covered service member:

____

First Middle Last

Name of covered service member for whom employee is requesting leave to care:

____

First Middle Last

Relationship of employee to covered service member requesting leave to care:

□ Spouse □ Parent □ Son □ Daughter □ Next of kin

Part B: Covered service member information

1. Is the covered service member a current member of the regular armed forces, the National Guard or Reserves, or a veteran? □ Yes □ No

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

   ____

   ____

If a veteran, when was the date of discharge? ____

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 medical hold or warrior transition unit)?
□ Yes □ No
If yes, provide the name of the medical facility or unit:
____

2. 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 covered service member and an estimate of the leave needed to provide the care:____
____
____

Section 2:

To be completed by a health care provider as defined by FMLA regulations

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 1 above has been completed before completing this section. Please be sure to sign the form on the last page.

Part A: Health care provider information

Health care provider's name and business address:

____
____
____

Type of practice/Medical specialty:____
____

Telephone (______)______________Fax (______)_________Email_____________________________

Part B: Medical status

1. 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 the 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". If such leave is requested, you may be required to complete the form *Certification of Health Care Provider for Family Member's Serious Health Condition.*)

2. Was the condition for which the covered service member is being treated incurred in line of duty on active duty in the armed force? □ Yes □ No
   If no, did the condition exist before the beginning of active duty and aggravated by service in the line of duty while on active duty? □ Yes □ No

3. Appropriate date condition commenced:____

4. Probable duration of condition and/or need for care:____

5. Is the covered service member undergoing medical treatment, recuperation or therapy?
   □ Yes □ No
   If yes, please describe medical treatment, recuperation or therapy:

   ____

   ____

Part C: Covered service member's need for care by family member

1. Will the covered service member 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 covered service member require periodic follow-up treatment appointments? □ Yes □ No
   If yes, estimate the treatment schedule:____

3. Is there a medical necessity for the service member to have periodic care for these follow-up treatment appointment? □ Yes □ No

4. 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 conditions)?
   □ Yes □ No
   If yes, estimate the frequency and duration of the periodic care.

   ____

____ ___________________________
Signature of health care provider Date