

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

Employee's 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

COVERED SERVICE MEMBER INFORMATION

- (1) 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 unit currently assigned to:

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 If yes, please provide the name of the medical treatment facility or unit:

-
- (2) Is the covered service member on the temporary disability retired list (TDRL)? ____ Yes ____ No

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:

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 ensure that Section I above has been completed before completing this section.) Please be sure to sign the form on the last page.

HEALTH CARE PROVIDER INFORMATION

Health care provider's name and business address:

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

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; or (4) a DOD non-network TRICARE authorized private health care provider:_____

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 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 DOL FORM WH-380 or an employer-provided form seeking the same information.)

(2) Was the condition for which the covered service member is being treated incurred in 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 covered service member undergoing medical treatment, recuperation, or therapy? ____ Yes ____ No. If yes, please describe medical treatment, recuperation or therapy:

THE GENETIC INFORMATION NON-DISCRIMINATION ACT OF 2008 ("GINA") PROHIBITS EMPLOYERS AND OTHER ENTITIES COVERED BY GINA TITLE II FROM REQUESTING OR REQUIRING GENETIC INFORMATION OF AN INDIVIDUAL OR A FAMILY MEMBER OF THE INDIVIDUAL, EXCEPT AS SPECIFICALLY ALLOWED BY THIS LAW. TO COMPLY WITH THIS LAW, WE ARE ASKING THAT YOU NOT PROVIDE ANY GENETIC INFORMATION WHEN RESPONDING TO THIS REQUEST FOR MEDICAL INFORMATION. 'GENETIC INFORMATION' AS DEFINED BY GINA, INCLUDES AN INDIVIDUAL'S FAMILY MEDICAL HISTORY, THE RESULTS OF AN INDIVIDUAL'S OR FAMILY MEMBER'S GENETIC TEST, THE FACT THAT AN INDIVIDUAL OR INDIVIDUAL'S FAMILY MEMBER SOUGHT OR RECEIVED GENETIC SERVICES, AND GENETIC INFORMATION OR A FETUS CARRIED BY AN INDIVIDUAL OR INDIVIDUAL'S FAMILY MEMBERS OR AN EMBRYO LAWFULLY HELD BY AN INDIVIDUAL OR FAMILY MEMBER RECEIVING ASSISTIVE REPRODUCTIVE SERVICES.

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 covered service member to have periodic care for these follow-up treatment appointments? ____ 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 condition)? ____ Yes ____ No If yes, please estimate the frequency and duration of the periodic care:
- _____
- _____

Signature of Health Care Provider: _____ **Date:** _____

PAPERWORK REDUCTION ACT NOTICE AND PUBLIC BURDEN STATEMENT

If submitted, it is mandatory for employers to retain a copy of this disclosure in their records for three years. 29 U.S.C. § 2616; 29 C.F.R. § 825.500. Persons are not required to respond to this collection of information unless it displays a currently valid OMB control number. The Department of Labor estimates that it will take an average of 20 minutes for respondents to complete this collection of information, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. If you have any comments regarding this burden estimate or any other aspect of this collection information, including suggestions for reducing this burden, send them to the Administrator, Wage and Hour Division, U.S. Department of Labor, Room S-3502, 200 Constitution AV, NW, Washington, DC 20210. **DO NOT SEND THE COMPLETED FORM TO THE WAGE AND HOUR DIVISION; RETURN IT TO THE EMPLOYER.**