



**CERTIFICATION FOR SERIOUS INJURY OR ILLNESS OF COVERED SERVICE-MEMBER
FOR MILITARY FAMILY LEAVE (FAMILY AND MEDICAL LEAVE ACT)**

Section I: Completion by the EMPLOYEE and/or the COVERED SERVICE-MEMBER 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.)

Part A: EMPLOYEE INFORMATION

Name and Address of Employer (this is the employer of the employee requesting leave to care for a covered service-member): _____

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? ___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, 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

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 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; or (3) a DOD non-network TRICARE authorized private health care provider. If you are unable to make certain of the military-related determination contained below in Part B, you are permitted to rely upon determination 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.

Part A: HEALTH CARE PROVIDER INFORMATION

Health Care Provider’s Name and Business Address: _____

Type of Practice/Medical Specialty: _____

Please indicate whether 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

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 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 the bedside. (Please note 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 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 29 C.F.R. 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 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 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 or 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 treatments 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