TULARE COUNTY

CERTIFICATION OF SERIOUS INJURY OR ILLNESS OF COVERED SERVICEMEMBER FOR MILITARY FAMILY LEAVE (FMLA)

SECTION I: For Completion by the EMPLOYEE and/or the COVERED SERVICEMEMBER for whom the Employee Is Requesting Leave

Instructions to the EMPLOYEE of COVERED 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 covered 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. (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 of Employee Requesting Leave to Care for Covered Servicemember:

_____

First Middle Last

_____

Department Title EE ID

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

_____

First Middle Last

Relationship of Employee to Covered Servicemember Requesting Leave to Care:
❑ SPOUSE ❑ PARENT ❑ SON ❑ DAUGHTER ❑ NEXT OF KIN

PART B: COVERED SERVICEMEMBER INFORMATION

(1) Is the Covered Servicemember a Current Member of the Regular Armed Forces, the National Guard or Reserves? ❑ Yes ❑ No

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

_____

Is the covered servicemember assigned to a military treatment facility as an outpatient or to a unit established for the purpose of providing command 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 Servicemember on the Temporary Disability Retired List (TDRL)?
❑ Yes ❑ No

PART C: CARE TO BE PROVIDED TO THE COVERED SERVICEMEMBER

Describe the Care to Be Provided to the Covered 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; 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).

Instructions to the HEALTH CARE PROVIDER: The employee listed above has requested leave under the FMLA to care for a family member who is a 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 active duty 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 covered servicemember's serious injury or illness includes written documentation confirming that the covered servicemember's injury or illness was incurred in the line of duty on active duty and that the covered 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.

(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:

_____

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:

Telephone: ( ) _____ Fax: ( ) _____

Email: _____

PART B: MEDICAL STATUS

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

(2) Was the condition for which the Covered Servicemember 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 or Return to Work Date:_____

(5) Is the covered servicemember undergoing medical treatment or recuperation?
❑ Yes ❑ No. If yes, please describe medical treatment, or recuperation:

_____

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

(1) Will the covered servicemember need care for a single continuous period of time, including any time for treatment and recovery? ❑ Yes ❑ No If Yes, duration of care period_____.

(2) Will the covered servicemember require periodic follow-up treatment appointments?
❑ Yes ❑ No. If yes, estimate the treatment schedule: _____

(3) Is there a medical necessity for the covered servicemember to have periodic care for these follow-up treatment appointments? ❑ Yes ❑ No

(4) Is there a medical necessity for the covered 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: _____

Address and Phone:_____

Please return this form to _____ (Name/Department)

Phone/FAX _____