

# Certification for Serious Injury or Illness of Covered Servicemember —for Military Family (Family and Medical Leave)

**Notice to the EMPLOYER**

**Instructions to the employer:** The Family and Medical Leave Act (FMLA) provides that an employer may require an employee seeking FML due to a serious injury or illness of a covered servicemember to submit certification providing sufficient facts to support the request for leave. Your response is voluntary. While you are not required to use this form, you may not ask the employee to provide more information than allowed under the FMLA regulations. 29 C.F.R. § 825.310. Employers must generally maintain records and documents relating to medical certifications, recertifications, or medical histories of employees or employees’ family members, created for FML purposes as confidential medical records in separate files/records from the usual personnel files and in accordance with 29 C.F.R. § 1630.14(c)(1), if the Americans with Disabilities Act applies.

**SECTION I**

**For completion by the EMPLOYEE and/or the COVERED SERVICEMEMBER for whom the employee is requesting leave.**

**Instructions to the employee or 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 FML 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 FML protections. 29 U.S.C. §§ 2613, 2614(c)(3). Failure to do so may result in a denial of an employee’s FML 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.

**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.**

**Instructions to the health care provider:** The employee listed on Page 2 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 FML, a serious injury or illness is one that was incurred in the line of duty on 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 FML 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 FML coverage. Limit your responses to the condition for which the employee is seeking leave.

**SECTION I**

**For completion by the EMPLOYEE and/or the COVERED SERVICEMEMBER for whom the employee is requesting leave.** (This section must be completed first before any of the following 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 covered servicemember):

Name of employee requesting leave to care for covered servicemember:

First

Middle

Last



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## 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?     No     Yes
- (3) Approximate date condition commenced: \_\_\_\_\_
- (4) Probable duration of condition and/or need for care: \_\_\_\_\_
- (5) Is the covered servicemember undergoing medical treatment, recuperation, or therapy?     No     Yes    If yes, please describe medical treatment, recuperation or therapy: \_\_\_\_\_

## 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?  
 No     Yes
- If yes, estimate the beginning and ending dates for this period of time: \_\_\_\_\_
- (2) Will the covered servicemember require periodic follow-up treatment appointments?     No     Yes
- 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?  
 No     Yes
- (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)?     No     Yes
- If yes, please estimate the frequency and duration of the periodic care: \_\_\_\_\_

Signature of health care provider \_\_\_\_\_ Date \_\_\_\_\_

Direct questions and return form and any required documentation to your department human resource professional. Keep a copy of this form for your personal records.