THE OHIO STATE UNIVERSITY

Certification for Serious Injury or Illness of Current Servicemember

for Military Family Leave (Family and Medical Leave)

SECTION 1: INSTRUCTIONS FOR COMPLETING THIS FORM

Instructions to the employer: The Family and Medical Leave Act (FMLA) provides that an employer may require an employee seeking FMLA leave due to a serious injury or illness of a current 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 FMLA 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, and in accordance with 29 CFR 1635.9, if the Genetic Information Nondiscrimination Act applies.

Section 2: For completion by the EMPLOYEE and/or the CURRENT SERVICEMEMBER for whom the employee is requesting leave.

Instructions to the employee or current servicemember: Please complete Section 2 before having Section 3 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.

Section 3: 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; (3) a DOD non-network TRICARE authorized private health care provider; or (4) a health care provider as defined in 29 CFR 825.125.

Instructions to the health care provider: The employee listed on Page 1 has requested leave under the FMLA to care for a family member who is a current 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 duty on active duty in the Armed Forces 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 current servicemember's serious injury or illness includes written documentation confirming that the servicemember's injury or illness was incurred in the line of duty on active duty or if not, that the current servicemember's injury or illness existed before the beginning of the servicemember's active duty and was aggravated by service in the line of duty on active duty in the Armed Forces, and that the current 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. Do not provide information about genetic tests, as defined in 29 CFR 1635.3(f), or genetic services, as defined in 29 CFR 1635.3(e).

SECTION 2: FOR COMPLETION BY THE EMPLOYEE

For completion by the EMPLOYEE and/or the CURRENT 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 of employee requesting leave to care for current servicemember:

Employee's Full Name: First M.I. Last OSU Employee ID# (required)

Name and address of employer (this is the employer of the employee requesting leave to care for current servicemember):

Name of Employer

Employer's Address: Street City State Zip

Name of current servicemember (for whom employee is requesting leave to care):

Current Servicemember's Full Name: First M.I. Last

Employee's Full Name: First | M.I. | Last | OSU Employee ID# (required)

SECTION 2: FOR COMPLETION BY THE EMPLOYEE (CONTINUED)

Relationship of employee to current servicemember requesting leave to care:

☐ Spouse/Domestic Partner ☐ Parent ☐ Son ☐ Daughter ☐ Next of Kin

Part B: Servicemember Information

1. Is the current servicemember a current member of the Regular Armed Forces, the National Guard or Reserves? ☐ No ☐ Yes

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

Is the servicemember 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)?

☐ No ☐ Yes If yes, please provide the name of the medical treatment facility or unit:

2. Is the servicemember on the Temporary Disability Retired List (TDRL)? ☐ No ☐ Yes

Part C: Care to Be Provided to the Servicemember

Describe the care to be provided to the current servicemember and an estimate of the leave needed to provide the care:

SECTION 3: FOR COMPLETION BY THE HEALTH CARE PROVIDER

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**
3. **a DOD non-network TRICARE authorized private health care provider**
4. **a health care provider as defined in 29 CFR 825.125**

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 has been completed before finishing this section.) Please be sure to sign the form on the last page.

Part A: Health Care Provider Information

Health Care Provider's Name | Type of Practice/Medical Specialty

Business Address: Street | City | State | Zip

Phone Number | Fax | Email 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; or (5) a health care provider as defined in 29 CFR 825.125:

Employee's Full Name: First M.I. Last OSU Employee ID# (required)

SECTION 3: FOR COMPLETION BY THE HEALTH CARE PROVIDER (CONTINUED)

Part B: Medical Status

1. Current 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 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 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 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. Is the current servicemember being treated for a condition which was incurred or aggravated by service 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 servicemember undergoing medical treatment, recuperation or therapy for this condition? ☐ No ☐ Yes

If yes, please describe medical treatment, recuperation or therapy:

_____

Part C: Servicemember's Need for Care by Family Member

1. Will the 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 servicemember require periodic follow-up treatment appointments? ☐ No ☐ Yes

If yes, estimate the treatment schedule: _____

3. Is there a medical necessity for the servicemember to have periodic care for these follow-up treatment appointments?

☐ No ☐ Yes

4. Is there a medical necessity for the 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

Keep a copy of this form for your personal records. Direct questions and return form and any required documentation to the assigned FML Administrator listed in Section 1 or to:

Office of Human Resources
Integrated Absence Management and Vocational Services
Email: hr-leaveadministrator@osu.edu
Phone: (614) 292-3439 (Option 3)
Fax: (614) 292-8844