Certification for Serious Injury or Illness of a Current Servicemember for Military Caregiver Leave under the Family and Medical Leave Act

U.S. Department of Labor Wage Hour Division



DO NOT SEND COMPLETED FORM TO THE DEPARTMENT OF LABOR. RETURN TO THE PATIENT.

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The Family and Medical Leave Act (FMLA) provides that eligible employees may take FMLA leave to care for a covered servicemember with a serious illness or injury. The FMLA allows an employer to require an employee seeking FMLA leave for this purpose to submit a medical certification. 29 U.S.C. §§ 2613, 2614(c)(3). The employer must give the employee at least 15 calendar days to provide the certification. If the employee fails to provide complete and sufficient certification, his or her FMLA leave request may be denied. 29 C.F.R. § 825.313. Information about the FMLA may be found on the WHD website at www.dol.gov/agencies/whd/fmla.

SECTION I - EMPLOYER

Either the employee or the employer may complete Section I. While use of this form is optional, it asks the health care provider for the information necessary for a complete and sufficient medical certification. You may not ask the employee to provide more information than allowed under the FMLA regulations, 29 C.F.R. § 825.310. Recertifications are not allowed for FMLA leave to care for a covered servicemember. Where medical certification is requested by an employer, an employee may not be held liable for administrative delays in the issuance of military documents, despite the employee's diligent, good-faith efforts to obtain such documents. An employer requiring an employee to submit a certification for leave to care for a covered servicemember must accept as sufficient certification invitational travel orders (ITOs) or invitational travel authorizations (ITAs) issued to any family member to join an injured or ill servicemember at the servicemember's bedside. An ITO or ITA is sufficient certification for the duration of time specified in the ITO or ITA.

Employers must generally maintain records and documents relating to medical information, 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 C.F.R. § 1635.9, if the Genetic Information Nondiscrimination Act applies.

(1) Employee name:				
	First	Middle	Last	
(2) Employer name:			Date:(List date certij	(mm/dd/yyyy) fication requested)
(3) This certification i	· · · · · · · · · · · · · · · · · · ·	eauested unless it is not feasil	ole despite the emplovee's diliger	(mm/dd/yyyy)

SECTION II - EMPLOYEE and/or CURRENT SERVICEMEMBER

Please complete all Parts of Section II before having the servicemember's health care provider complete Section III. The FMLA allows 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 your employer, your response is required to obtain or retain the benefit of FMLA-protected leave.

PART A: EMPLOYEE INFORMATION

(1) T	C .1	t servicemember	C 1	1 .	. 1
/ I N N 21	ne of the current	t ceruicemember	tor whom em	niovee is re	aniectina leav
(1) 114	ne or me current		TOT WHOTH CITE	ipioyee is it	questing icav

Em	Employee Name:						
(2)	Select your relationship	p to the current service	member. You are the c	urrent servicemember's:			
	☐ Spouse	☐ Parent	☐ Child	□ Next of Kin			
mar obli of a serv of k (1):	riage or same-sex marria gations of a parent to a cha a parent to the employer ricemember for whom the in" is the servicemember a blood relative as designa	ge. The terms "child" and ild. An employee may take when the employee we employee has assumed the service of the content of th	d "parent" include <i>in loc</i> the FMLA leave to care for as a child. An employe the obligations of a parent other than the spouse, par accemember for purposes of	the individual was married, o parentis relationships in what a covered servicemember when may also take FMLA lead. No biological or legal relationships, or daughter, in the fif FMLA leave, (2) blood relances, and (6) first cousins.	hich a person assumes the no assumed the obligations we to care for a covered onship is necessary. "Next following order of priority:		
<u>PA</u>	RT B: SERVICEME	MBER INFORMATION	ON AND CARE TO B	E PROVIDED TO THE	<u>SERVICEMEMBER</u>		
) The servicemember (□ is / □ is not) a current member of the Regular Armed Forces, the National Guard or Reserves. If yes, provide the servicemember's military branch, rank and unit currently assigned to:						
	established for the purposer as outpatients, such facility or unit:	pose of providing comments as a medical hold or	nand and control of me warrior transition unit.		s receiving medical		
(5)	The servicemember (\square is $/\square$ is not) on the	Temporary Disability I	Retired List (TDRL).			
(6)	Briefly describe the care you will provide to the servicemember: (Check all that apply) Assistance with basic medical, hygienic, nutritional, or safety needs						
	☐ Psychologica	l Comfort	☐ Physical Car				
	☐ Transportation	n	☐ Other:				
(7)	7) Give your best estimate of the amount of leave needed to provide the care described:						
(8)	If a reduced work schedule is necessary to provide the care described, give your best estimate of the reduced work						
	schedule you are able	e to work. From	(mm/dd/yy	yy) to	(mm/dd/yyyy), I am		
	able to work:		(hours per	day)	(days per week).		
			· · •				

SECTION III - HEALTH CARE PROVIDER

Please provide your contact information, complete all Parts of this Section fully and completely, and sign the form below. The employee listed at Section I 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. Note: 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 or that existed before the beginning of the member's active duty and was aggravated by service in the line of duty on active duty in the Armed Forces that may render the servicemember medically unfit to perform the duties of the servicemember's office, grade, rank, or rating. "Need for care" includes both physical and psychological care. It includes situations where, for example, due to his or her serious injury or illness, the servicemember is not able to care for his or her own basic medical, hygienic, or nutritional needs or safety, or needs transportation to the doctor. It also includes providing psychological comfort and reassurance which would be beneficial to the servicemember who is receiving inpatient or home

Emp	ployee Name:
injur line servi	A complete and sufficient certification to support a request for FMLA leave due to a current servicemember's serious by or illness includes written documentation confirming that the servicemember's injury or illness was incurred in the of duty on active duty or if not, that the current servicemember's injury or illness existed before the beginning of the icemember's active duty and was aggravated by service in the line of duty on active duty in the Armed Forces, and that current servicemember is undergoing treatment for such injury or illness by a health care provider listed above.
<u>PAF</u>	RT A: HEALTH CARE PROVIDER INFORMATION
Heal	th Care Provider's Name: (Print)
Heal	th Care Provider's business address:
Тур	e of practice/Medical specialty:
Tele	phone: () Fax: () E-mail:
Plea	se select the type of FMLA health care provider you are:
DAT	□ DOD TRICARE network authorized private health care provider □ DOD non-network TRICARE authorized private health care provider □ Health care provider as defined in 29 C.F.R. § 825.125
Plea servi deter	se provide appropriate medical information of the patient as requested below. Limit your responses to the icemember's condition for which the employee is seeking leave. If you are unable to make some of the military-related rminations contained below, you are permitted to rely upon determinations from an authorized DOD representative, as a DOD recovery care coordinator. Do not provide information about genetic tests, as defined in 29 C.F.R. § 5.3(f), or genetic services, as defined in 29 C.F.R. § 1635.3(e).
(1)	Patient's Name:
(2)	List the approximate date condition started or will start: (mm/dd/yyyy)
(3)	Provide your best estimate of how long the condition will last:
(4)	The servicemember's injury or illness: (Select as appropriate)
	 □ Was incurred in the line of duty on active duty. □ Existed before the beginning of the servicemember's active duty and was aggravated by service in the line of duty on active duty. □ None of the above.
(5)	The servicemember (\square is / \square is not) undergoing medical treatment, recuperation, or therapy for this condition. If yes, briefly describe the medical treatment, recuperation or therapy:

Emp.	loyee Name:					
(6)	The current servicemember's medical condition is classified as: (Select as appropriate)					
	□ (VSI) Very Seriously Ill/Injured Illness/Injury is of s members are requested at bedside immediately. <i>Please used by DOD healthcare providers</i> .					
	☐ (SI) Seriously Ill/Injured Illness/injury is of such ser is no imminent danger to life. Family members are recasualty assistance designation used by DOD healthcare p	equested at bedside. Please note this is an internal DC				
	□ OTHER III/Injured A serious injury or illness that n the duties of the member's office, grade, rank, or ratin	•	erform			
	□ NONE OF THE ABOVE. Note to Employee: If this be a covered family member with a "serious health condition requested, you may be required to complete DOL FORM Winformation.	" under 29 C.F.R. § 825.113 of the FMLA. If such leave	e is			
PAR'	T C: AMOUNT OF LEAVE NEEDED					
a cond of the	ne medical condition checked in Part B, complete all that apply. So dition, treatment, etc. Your answer should be your best estimate be a patient. Be as specific as you can; terms such as "lifetime," "un A coverage.	sed upon your medical knowledge, experience, and exam	mination			
(7)	Due to the condition, the servicemember will need care for treatment and recovery. Provide your best estimate of the end date (mm/dd/yyyy) for this period of	ne beginning date (mm/dd/yyyy)				
(8)	Due to the condition, it is medically necessary for the ser appointments (scheduled medical visits). Provide your b any period(s) of recovery	est estimate of the duration of the treatment(s), ind	cluding			
(9)	Due to the condition, it is medically necessary for the servicemember to receive care on an intermittent basis (periodically), such as the care needed because of episodic flare-ups of the condition or assisting with the servicemember's recovery. Provide your best estimate of how often (frequency) and how long (the duration) the intermittent episodes will likely last.					
	Over the next 6 months, intermittent care is estimated to	occurtime	s per			
	(\square day / \square week / \square month) and are likely to last approepisode.	ximately (hours / days) per				
	ature of	Data	11/			
неап	th Care Provider	Date(mm/d	a/yyyy)			

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, in accordance with 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 15 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 Avenue, N.W., Washington, D.C. 20210.

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