Family Medical Leave

Certification for Serious Injury or Illness of Covered Servicemember for Military Family Medical Leave

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.

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 in Section I has requested leave under the Family Medical Leave Act (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 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 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. Answer, fully and completely, all applicable parts. Several questions seek a response as 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.

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 sections below 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

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

_____

First Middle Last

Relationship of Employee to Covered Servicemember Requesting Leave to Care for:

☐ 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? ___No___Yes

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

   _____

2. Is the Covered Servicemember on the Temporary Disability Retired List (TDRL)? ___No___Yes

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. Instructions to the 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). 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 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; or (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 an employer provided form seeking the same information.)

2. Was the condition for which the Covered Serivicemember is being treated incurred in the line of 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 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**

Return Completed Form to: **Lamar University/Lamar Institute of Technology Human Resources Office**
PO Box 11127 Beaumont, TX 77710 or Fax to (409) 880-8464