

**Certification for Serious Injury or Illness
Of Covered Servicemember for
Military Family Leave
(Family and Medical Leave Act)**

U.S. Department of Labor
Employment Standards Administration
Wage and Hour Division

**Adopted by
Iowa County
January 2009**

OMB Control Number 1215-0181

Notice to the EMPLOYER INSTRUCTIONS to the EMPLOYER: The Family and Medical Leave Act (FMLA) provides that employer may require an employee seeking FMLA leave due to a serious injury or illness of a servicemember to submit a 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 certification, 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.

SECTION I: For Completion by the EMPLOYEE and/or 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 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 II: 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 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 cover 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 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.

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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 below 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 a covered servicemember): _____

Name of Employee Requesting Leave to Care for Covered Servicemember:

First Middle Last

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

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 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 medical hold or warrior transition unit)? _____ Yes _____ No

If yes, please provide the name of the medical treatment 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 (DO) 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 determination contained below in Part B, you are permitted 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 Lines):

_____ (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 a 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 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 Service member is being treated incurred in line of duty on active duty in the armed forces? _____ Yes _____ No

(3) Approximate date condition commenced: _____

(4) Probably duration of condition and/or need for care: _____

(5) Is the covered servicemember undergoing medical treatment, recuperation or therapy? _____ Yes _____ No

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? _____ Yes _____ No

If yes, estimate the beginning and ending dates for this period of time: _____

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

(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: _____

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. 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 20 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 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 Ave., NW, Washington, DC 20210. **DO NOT SEND COMPLETED FORM TO THE DEPARTMENT OF LABOR: RETURN TO THE PATIENT.**