Certification for Serious Injury or Illness of a Covered Service member (FMLA)

SECTION I: For Completion by the Employee and/or the Covered Service member for whom the Employee is Requesting Leave
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 service member. If requested by the employer, your response is required to obtain or retain the benefit of FMLA-protected leave. Failure to do so may result in a denial of an employee's FMLA request. You have 15 calendar days to return this form to **Employee Health 205.975.6900**

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:

A complete and sufficient certification to support a request for FMLA leave due to a covered service member's serious injury or illness includes written documentation confirming that the covered service member's injury or illness was incurred in the line of duty on active duty and that the covered service member 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 or genetic services.

SECTION I. For Completion by the EMPLOYEE and or the COVERED SERVICEMEMBER for whom the Employee is requesting Leave

Part A: EMPLOYEE INFORMATION

Employee Full Name: _____ Employee ID Number: _____

Job Title: _____ Employee Phone Number: _____

Department: _____ Department Contact Number: _____

Name of Covered Servicemember (for whom employee is requesting leave to care): _____
Last Name First Name MI

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 or a Veteran*?

   _____ 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 mlitary 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)?

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

   _____

   _____

2. Is the Covered Servicemember on the Temporary disability Retired List (TDRL)? _____ Yes _____ No

*Note: 2010 NDAA Amendment: A Covered Service Member is a current member of the Armed Forces, including regular components of the National Guard and Reserves as well as veterans who are undergoing medical treatment, recuperation, or therapy for a serious injury or illness and who was a member of the Armed Forces (including National Guard or Reserves) at any time during the five year period preceding the date on which the veteran undergoes that medical treatment, recuperation or therapy.

Part C: CARE TO BE PROVIDED TO THE COVERED SERVICE MEMBER

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: 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: (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. (This is an internal DOD casualty assistance designation used by DOD healthcare 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. (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 ix checked, you may still be eligible to take leave to care for a covered family member with a "serious health condition".)

(2) Was the condition for which the Covered Servicemember is being treated incurred in line of duty on active duty in the Armed Forces? _____ Yes _____ No

(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? _____ Yes_____ No If yes, please describe medical treatment, recuperation or therapy:

_____

_____

*Note: 2010 NDAA Amendment: For a current member of the Armed Forces the definition is amended to include not only a serious injury or illness that was incurred by the member in line of duty on active duty but also a serious injury or illness that "existed before the beginning of the member's active duty and was aggravated by service in line of duty on active duty in the Armed Forces" that may render the member medically unfit to perform the duties of the member's office, grade, rank, or rating. For a veteran, a serious injury or illness is defined as "a qualifying injury or illness that was incurred by the member in line of duty on active duty in the Armed Forces (or existed before the beginning of the member's active duty and was aggravated by service in line of duty on active duty in the Armed Forces) and that manifested itself before or after the member became a veteran." The 2010 NDAA directs the Secretary of Labor to define "qualifying injury or illness" of a veteran.

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 end dates for this period of time: _____

(2) Will the covered servicemember require periodic follow-up treatment appointments? _____

_____ Yes _____ No 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? _____ 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