

**Family and Medical Leave Act  
CERTIFICATION FOR SERIOUS INJURY OR ILLNESS OF  
COVERED SERVICEMEMBER FOR MILITARY FAMILY LEAVE**

**SECTION I: For Completion by the EMPLOYEE and/or the COVERED SERVICEMEMBER for whom the Employee is Requesting Leave.**

Please complete this section before giving this form to your family member or his/her medical provider.

<b>PART A: EMPLOYEE INFORMATION</b>
Name of Employee Requesting Leave to Care for Covered Servicemember:
Name of Covered Servicemember (for whom employee is requesting leave to care):
Relationship of Employee to Covered Servicemember Requesting Leave to Care: <input type="checkbox"/> Spouse <input type="checkbox"/> Parent <input type="checkbox"/> Son <input type="checkbox"/> Daughter <input type="checkbox"/> Next of Kin
<b>PART B: COVERED SERVICEMEMBER INFORMATION</b>
Is the Covered Servicemember a Current Member of the Regular Armed Forces, the National Guard or Reserves? <input type="checkbox"/> Yes <input type="checkbox"/> No
If yes, please provide the covered servicemember's military branch, rank and unit currently assigned to:
Is the Covered Servicemember on the Temporary Disability Retired List (TDRL)? <input type="checkbox"/> Yes <input type="checkbox"/> No
<b>PART C: CARE TO BE PROVIDED TO THE COVERED SERVICEMEMBER</b>
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 HEALTH CARE PROVIDER who is either (1) a United States Department of Veterans Affairs ("VA") healthcare provider (2) a DOD TRICARE network authorized private health care provider (3) a DOD non-network TRICARE authorized private health care provider or (4) meets the definition under Section 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).

<b>PART A: HEALTH CARE PROVIDER INFORMATION</b>
Health Care Provider's Name and Business Address:
Type of Practice/Medical Specialty:

Please state whether you are a:

- DOD health care provider
- VA health care provider
- DOD TRICARE network authorized private health care provider
- DOD non-network TRICARE authorized private health care provider
- Health care provider not affiliated with DOD, VA, or TRICARE as defined in Section 825.125.

Telephone:

Fax:

Email:

### **PART B: MEDICAL STATUS**

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. (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 the *FMLA Certification of Health Care Provider for Family Member's Serious Health Condition* form.)

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

Approximate date condition commenced:

Probable duration of condition and/or need for care:

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 NEED FOR CARE BY FAMILY MEMBER**

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:

Will the covered servicemember require periodic follow-up treatment appointments?  Yes  No

If yes, estimate the treatment schedule:

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

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