

Human Resources
1980 Arthur Street
Louisville, KY 40208-2770
Attn: Cammie Bordenkircher
Phone: 502.852.0682
Fax: 502.852.5665

**Certification for Serious Injury or
Illness of Covered Service member
For Military Family Leave
(Family & Medical Leave Act)**

Notice to the EMPLOYER

INSTRUCTIONS to the EMPLOYER: The Family and Medical Leave Act (FMLA) provides that an employer may require an employee seeking FMLA leave due to a serious injury or illness of a covered service member 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 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.

SECTION I: For Completion by the EMPLOYEE and/or the COVERED SERVICE MEMBER for whom the Employee Is Requesting Leave

INSTRUCTIONS to the EMPLOYEE or COVERED SERVICE MEMBER: 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. 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: 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 on Page 2 has requested leave under the 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 service member 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 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.

**Certification for Serious Injury or
Illness of Covered Service member
For Military Family Leave
(Family & Medical Leave Act)**

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 of Employer (this is the employer of the employee requesting leave to care for covered service member): _____

Address of Employer: _____

Name of Employee Requesting Leave to Care for Covered Service member:

First

Middle

Last

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

First

Middle

Last

Relationship of Employee to Covered Service member Requesting Leave to Care:

Spouse

Parent

Son

Daughter

Next of Kin

Part B: COVERED SERVICE MEMBER INFORMATION

1. Is the Covered Service member a Current Member of the Regular Armed Forces, the National Guard or Reserves? ___ Yes ___ No.

If yes, please provide the covered service member’s military branch, rank and unit currently assigned to:

Is the covered service member 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 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 Service member on the Temporary Disability Retired List (TDRL)? ___ Yes ___ No.

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

Describe the Care to Be Provided to the Covered Service member 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: _____

Health Care Provider's Address: _____

Type of Practice/Medical Specialty: _____

Please state whether you are either:

- a DOD health care provider;
- a VA health care provider;
- a DOD TRICARE network authorized private health care provider; or
- a DOD non-network TRICARE authorized private health care provider:

Telephone: () _____ Fax: () _____

Email: _____

PART B: MEDICAL STATUS

1. Covered Service member'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 service member 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

§ 25.113 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. Probable duration of condition and/or need for care: _____

5. Is the covered service member undergoing medical treatment, recuperation, or therapy?
 Yes No.

If yes, please describe medical treatment, recuperation or therapy:

PART C: COVERED SERVICE MEMBER'S NEED FOR CARE BY FAMILY MEMBER

1. Will the covered service member 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. Will the covered service member require periodic follow-up treatment appointments?
 Yes No. If yes, estimate the treatment schedule:

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

4. Is there a medical necessity for the covered service member 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:** _____