SOUTHERN ILLINOIS UNIVERSITY EDWARDSVILLE

FMLA Medical Certification: Covered Service Member

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SECTION I: For completion by the EMPLOYEE and/or the COVERED SERVICE MEMBER for whom the employee is requesting leave.
Please complete this section before giving this form to your family member or his/her medical provider.

PART A: EMPLOYEE INFORMATION

Employee's Name (Last, First): _____ Banner ID: 800

Information of covered service member (for whom employee is requesting leave to care):

Name: _____ Relationship: _____

PART B: COVERED SERVICE MEMBER INFORMATION

4. 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:

_____

If no, please provide date veteran left active military service: _____

5. 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: _____

_____

6. 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

7. 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 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) a health care provider as defined in 29.CFR.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).

FMLA to care for a family member who is a current 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 in the Armed Forces or that existed before the beginning of the member's active duty and was aggravated by service in the line of duty on active duty in the Armed Forces 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 current servicemember's serious injury or illness includes written documentation confirming that the servicemember's injury or illness was incurred in the line of duty on active duty or if not, that the current servicemember's injury or illness existed before the beginning of the servicemember's active duty and was aggravated by service in the line of duty on active duty in the Armed Forces, and that the current 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 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 servicemember's condition for which the employee is seeking leave.

PART A: HEALTH CARE PROVIDER INFORMATION

8. Name of Health Care Provider: _____

9. Address of Health Care Provider: _____

10. Telephone: _____ Fax: _____ Email: _____

11. Type of practice/medical specialty: _____

12. 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
- ☐ A health care provider as defined in 29.CFR.825.125

PART B: MEDICAL STATUS

13. 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. (**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 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.)

14. Was the condition for which the covered service member is being treated incurred in line of duty on active duty in the armed forces?

15. Approximate date condition commenced: _____

16. Medical diagnosis of condition: _____

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

18. 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 NEED FOR CARE BY FAMILY MEMBER

19. 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: _____

_____

20. Will the covered service member require periodic follow-up treatment appointments?

☐ Yes ☐ No

If yes, estimate the treatment schedule: _____

_____

21. Is there a medical necessity for the covered service member to have periodic care for these follow-up treatment appointments?

☐ Yes ☐ No

22. 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: _____

_____

Authorized Signature of Health Care Provider: _____

Print Name: _____ Date: _____

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H.R. Approval: ☐ Yes ☐ No **Authorized Signature:** _____

The Genetic Information Nondiscrimination Act of 2008 (GINA) prohibits employers and other entities covered by GINA Title II from requesting or requiring genetic information of an individual or family member of the individual, except as specifically allowed by this law. To comply with this law, we are asking that you not provide any genetic information when responding to this request for medical information. `Genetic information' as defined by GINA, includes an individual's family medical history, the results of an individual's or family member's genetic tests, the fact that an individual or an individual's family member sought or received genetic services, and genetic information of a fetus carried by an individual or an individual's family member or an embryo lawfully held by an individual or family member receiving assistive reproductive services.