

HEALTHCARE PROVIDER INFORMATION

Must be completed 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, you are permitted to rely upon determinations from an authorized DOD representative (such as a DOD recovery care coordinator).**
Please be sure to sign the form on the last page.

The employee listed on page 1 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 a 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 covered servicemember is undergoing treatment for such injury or illness by a health care provider listed below. 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.

MEDICAL STATUS

(1) Covered Servicemembers medical condition is classified as (Check One of the Appropriate Boxes):

(VSI) Very Seriously Ill/Injured – Illness/Injury is at such a severity that life is imminently endangered. Family members are requested at bedside immediately. (Please note this is an internal DOD casualty assistant destination used by DOD health care providers.)

(SI) Seriously Ill/Injured – Illness/Entry is of such severity that there is cause for immediate concern, but there is no imminent danger of life. Family members are requested at bedside. (Please note this is an internal DOD casualty assistant destination used by DOD health care 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 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:

COVERED SERVICEMEMBERS 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) 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: _____

Health Care Providers Name and Business Address:

Type Practice/Medical Specialty: _____

Please state whether you either: (1) a DOD health care provider; (2) a VA health care provider; (3) a DOD TRICARE network authorized private healthcare provider; or (4) a DOD non-network TRICARE authorized private healthcare provider: _____

Telephone: () _____ Fax: () _____

Email: _____

Signature of Health Care Provider: _____ **Date:** _____

Signature of Employee: _____ **Date:** _____