Stanislaus County
CEO- Risk Management Division
1010 10th Street Suite 5900, Modesto, CA 95354
Phn 209-525-5710 Fax 209-525-5779

Medical Certification
Serious Injury or Illness of a Current Service member
(Family & Medical Leave Act – Military Caregiver Leave)
SERVICE MEMBER

EMPLOYEE: The FMLA permits an employer to require that you submit a timely, complete and sufficient certification to support a request for FMLA leave. Employee ID #:_____

Employee: _____ Department: _____

Employee Requesting Leave Beginning: _____ Date Expected Return to Work: _____

Service member's Name: _____

Relationship to employee: ☐ Spouse ☐ Parent ☐ Son ☐ Daughter ☐ Next of Kin _____

☐ Current member of the Regular Armed Forces ☐ National Guard ☐ Reserves ☐ Other _____

Service member's military branch, rank and unit currently assigned: _____

Signature of Employee: _____ Date:_____
I certify that the statements made by me are true and correct to the best of my knowledge.

TO BE COMPLETED BY HEALTH CARE PROVIDER

UNITED STATES DEPARTMENT OF DEFENSE (DOD), PATIENT'S HEALTH CARE PROVIDER (Veterans Affairs (VA) health care provider, DOD TRICARE provider or other health care provider) INSTRUCTIONS: The employee identified above has requested leave under the 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 disabled list for a serious injury or illness. Please answer, fully and completely, all questions below. 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" are not sufficient to determine FMLA coverage. Please be sure to sign the form on the last page. DO NOT TO DISCLOSE THE UNDERLYING DIAGNOSIS WITHOUT THE WRITTEN CONSENT OF THE PATIENT:

1) Is the 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 Service member on the Temporary Disability Retired list (TDRL)? ☐Yes☐ No

3) Describe the care to be provided to the service member and an estimate of the leave needed to provide the care:

_____

_____

4) The current Service member's medical condition is classified as:
   ☐(VSI) Very Seriously Ill/Injured – Illness/Injury is of such a severity that life is imminently endangered. Family members are requested at bedside immediately.

☐ (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.

☐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

5) Is the current Service member being treated for a condition, which was incurred or aggravated by service in the line of duty on active duty in the Armed Forces? ☐Yes☐ No

6) Approximate date condition commenced: _____

7) Probable duration of condition and /or need for care: _____

8) Is the service member undergoing medical treatment, recuperation, or therapy for this condition?
☐Yes☐ No
If yes, please describe the medical treatment, recuperation or therapy:
_____

9) Will the service member need care for a single continuous period, including any time for treatment and recovery?
☐Yes☐ No
If yes, estimate the beginning and ending dates for this period:
_____

10) Will the service member require periodic follow-up treatment appointments? ☐Yes☐ No
If yes, estimate the treatment schedule:
_____

11) Is there a medical necessity for the service member to have periodic care for these follow-up treatment appointments?
☐Yes☐ No
12) Is there a medical necessity for the service member to have periodic care for other than scheduled follow-up treatment and appointments (e.g. episodic flare-ups of medical condition)? ☐Yes☐ No
If yes, please estimate the frequency and duration of the periodic care:
_____

_____

☐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 or ☐Health Care Provider as defined in 29 CFR 825.125

Name of Treating Health Care Provider:	License #:	Phone:	Fax:
Business address:	Medical Specialty:		
_____ Signature of Treating Health Care Provider	_____ Date		

I certify that I am the physician providing care for the patient identified in this document and that the statements made by me are true and correct to the best of my knowledge.

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.