

Employee Name _____

3. The servicemember (is / is not) on the Temporary Disability Retired List (TDRL).
4. Briefly describe the care you will provide to the servicemember: *(Check all that apply)*
 Assistance with basic medical, hygienic, nutritional, or safety needs Transportation
 Psychological Comfort Physical Care Other _____
5. Give your **best estimate** of the amount of FMLA leave needed to provide the care described: _____

6. If a **reduced work schedule** is necessary to provide the care described, give your **best estimate** of the reduced schedule you are able to work. From _____ (mm/dd/yyyy) to _____ (mm/dd/yyyy).
I am able to work _____ (hours per day) _____ (days per week).

SECTION III: For Completion by the HEALTH CARE PROVIDER:

Please provide your contact information, complete all Parts of this Section fully and completely, and sign the form below. The employee listed in Section I 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 disability retired list for a serious injury or illness.

Note: 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 servicemember'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 the servicemember's office, grade, rank, or rating. "Need for care" includes both physical and psychological care. It includes situations where, for example, due to his or her serious injury or illness, the servicemember is not able to care for his or her own basic medical, hygienic, or nutritional needs or safety, or needs transportation to the doctor. It also includes providing psychological comfort and reassurance which would be beneficial to the servicemember who is receiving inpatient or home care. 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.

PART A: HEALTH CARE PROVIDER INFORMATION

Health Care Provider's Name: *(Print)* _____

Health Care Provider's business address: _____

Type of Practice/Medical Specialty: _____

Telephone: _____ Fax: _____ Email: _____

Please select the type of FMLA health Care provider you are:

- 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 as defined in 29 CFR 825.125

PART B: MEDICAL INFORMATION

Please provide appropriate medical information of the patient as requested below. Limit your responses to the servicemember's condition for which the employee is seeking leave. If you are unable to make some 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. Do not provide information about genetic tests, as defined in 29 C.F.R. § 1635.3(f), or genetic services, as defined in 29 C.F.R. § 1635.3(e).

1. Patient's Name: _____

Employee Name _____

2. List the approximate date condition started or will start: _____ (mm/dd/yyyy)
3. Provide your **best estimate** of how long the condition will last: _____
4. The servicemember's injury or illness: *(Select as appropriate)*
 - Was incurred in the line of duty on active duty
 - Existed before the beginning of the servicemember's active duty and was aggravated by service in the line of duty on active duty
 - None of the above

The servicemember (is / is not) undergoing medical treatment, recuperation, or therapy for this condition.

If yes, briefly describe the medical treatment, recuperation or therapy: _____

5. The current servicemember's medical condition is: *(Select as appropriate)*
 - (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 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 29 C.F.R. § 825.113 of the FMLA. If such leave is requested, you may be required to complete the FML Certification for Family Member Health Condition form.*

PART C: Amount of Leave Needed

For the medical condition checked in Part B, complete all that apply. Some 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 military caregiver leave coverage.

1. Due to the condition, the servicemember will need care for a **continuous period of time**, including any time for treatment and recovery. Provide your **best estimate** of the beginning date _____ (mm/dd/yyyy) and end date _____ (mm/dd/yyyy) for this period of time.
2. Due to the condition, it is medically necessary for the servicemember to attend **planned medical treatment** appointments (scheduled medical visits). Provide your **best estimate** of the duration of the treatment(s), including any period(s) of recovery _____ (e.g. 3 days/week)
3. Due to the condition, it is medically necessary for the servicemember to receive care on an **intermittent basis** (periodically), such as the care needed because of episodic flare-ups of the condition or assisting with the servicemember's recovery. Provide your **best estimate** of how often (frequency) and how long (duration) the episodes of incapacity will likely last.

Over the next 6 months, intermittent care is estimated to occur _____ times per
(day / week / month) and are likely to last approximately _____ (hours / days) per episode.

Signature of Health Care Provider: _____ Date: _____