Division of Human Resources

Family Medical Leave Act (FMLA)
Certification of Health Care Provider for *Covered (Military) Service Member*

SECTION I: For completion by the EMPLOYEE and/or the COVERED SERVICE MEMBER for whom the employee is requesting leave: (This section must be completed before any of the below sections can be completed by a health care provider.)

PART I-A: EMPLOYEE INFORMATION

Employee's Name:_____ Employee ID#:_____

Provide name of covered service member for who the employee is requesting leave to care for:

Covered Service Member Name:_____

Relationship of Employee to Covered Service Member: ☐Spouse ☐Parent ☐Son ☐Daughter ☐Next of Kin

PART I-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, provide the covered service member's military branch, rank, and unit currently assigned.

   _____

   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 or the Armed Forces who are receiving medical care as outpatients (Such as a medical hold or warrior transition unit)? ☐Yes ☐No

   If yes, provide the name of the medical treatment facility or unit name:_____

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

PART I-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 duration needed to provide 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 provided; (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 unauthorized DOD representative (such as a DOD recovery care coordinator). (Section I above **must be** completed before completing this section.) **Be sure to sign Page 2 of this form.**

PART II-A: HEALTH CARE PROVIDER INFORMATION

Health Care Provider Name:_____

Type of Practice/Medical Specialty:_____

Health Care Provider Business Address:_____

Telephone #:_____ Fax #:_____ E-mail Address:_____

PART II-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. (Note this is an internal DOD causality assistance designation used by DOD health care 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. (Note this is an internal DOD causality assistance designation used by DOD health care 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 a FMLA Health Care Provider for Family Member's Serious Health Condition Certification (PBSD 2313) form.

2. Was the condition for which the covered service member is being treated incurred in the 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, describe medical treatment, recuperation or therapy?

   _____

PART II-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

3. Is there medical necessity for the covered service member to have periodic care for other than scheduled 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, estimate the frequency and duration of the periodic care _____

_____ _____

Signature of Health Care Provider *Date*