San Joaquin County: Certification for Serious Injury or Illness of Covered Servicemember (FMLA)

Section I: to be completed by Employee and/or the Covered Servicemember

INSTRUCTIONS to the EMPLOYEE or COVERED SERVICEMEMBER: Please complete Section I before having Section II completed. Failure to provide a complete and sufficient medical certification within **15 calendar** days from the date of this notice may result in a denial of or delay in the processing of your FMLA request.

Part A: Employee Information

Name of employee requesting leave to care for covered servicemember:

_____

First Middle Last Employee ID #

Department Name:

_____

Name of covered servicemember (for whom the employee is requesting leave to care):

_____

First Middle Last

Relationship of covered servicemember to the employee requesting leave to provide care:

☐ SPOUSE ☐ PARENT ☐ SON ☐ DAUGHTER ☐ NEXT OF KIN

Part B: Covered Servicemember Information

1. Is the covered servicemember a current member of the regular Armed Forces, the National Guard or Reserves? ☐ **Yes** ☐ **No**

If yes, please provide the covered servicemember's military branch, rank and unit assignment:

_____

Is the covered servicemember assigned to a military treatment facility as an outpatient or to a unit established for the purpose of providing command 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 covered servicemember on the Temporary Disability Retired List (TDRL)? ☐ **Yes** ☐ **No**

Part C: Care to be Provided to the Covered Servicemember

Describe the care to be provided to the covered servicemember and an estimate of the time off work needed to provide the care:

_____

_____

Section II: to 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 in part B, you are permitted to rely upon determinations from an authorized DOD representative (such as a DOD Recovery Care Coordinator).

(Please ensure that Section I has been completed before completing this section.) Please be sure to sign the form on the last page

INSTRUCTIONS to the HEALTH CARE PROVIDER: The employee listed in Section I has requested leave under the Family and Medical Leave Act (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 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 active duty that may render the servicemember medically unfit to perform the duties of his or her office, grade, rank, or rating. 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.

****Note**: Any administrative costs associated with the completion of this form by the medical provider are the sole responsibility of the employee.

Part A: Health Care Provider Information

(Print) Health Care Provider's Name and Business Address:

_____

Type of Practice/Medical Specialty:_____

Telephone: ( ) _____ Fax: ( ) _____ Email: _____

Please check whether you are either: □ a DOD healthcare provider; □ a VA healthcare provider; □ a DOD TRICARE network authorized private healthcare provider; or □ a DOD non-network TRICARE authorized private healthcare provider:

Part B: Medical Status

1. Covered Servicemember's medical condition is classified as (Check One of the Appropriate Boxes):

□ **(VSI) Very Serious Illness/Injury** – Illness/ Injury is or 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) Serious Illness/Injury** – 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 Illness/Injury** – 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 the County's Health Care Provider's Certification Form** (For Family Member's Serious Health Condition).

2. Was the condition for which the servicemember is being treated incurred in 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 servicemember undergoing medical treatment, recuperation, or therapy? □ **No** □ **Yes**.

Part C: Covered Servicemember's 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, estimate the frequency and duration of the periodic care:

Frequency: _____ times per _____ week(s) _____month(s) AND **Duration:** _____ hours or ___ day(s) per episode

Health Care Provider's Signature: _____ Date_____

****Note**: Any administrative costs associated with the completion of this form by the medical provider are the sole responsibility of the employee.