CERTIFICATION BY SERVICE MEMBER'S HEALTH CARE PROVIDER FOR CAREGIVER MILITARY FAMILY LEAVE – FMLA

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.)

Name of Employee Requesting Leave to Care for Covered Service member:

_____

Name of Covered Service Member (for whom employee is requesting leave to care):

_____

Relationship of Employee to Covered Service Member:

____ Spouse ____ Parent ____ Son ____ Daughter ____ Next of Kin

Is the Covered Service Member a Current Member of the Regular Armed Forces, the National Guard or Reserves? ____ Yes ____ No

If yes, please provide the covered service member's military branch, rank and unit currently assigned to:

_____

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 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: _____

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

Describe the care to be provided to the covered service member and an estimate of the leave needed to provide the 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 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 above has been completed before completing this section.) Please be sure to sign the form on the last page.

Health Care Provider's Name (Please print):

Health Care Provider's Signature: **Date:**

Address:

Phone number: **Fax number:**

Specialty/Type of Practice:

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

MEDICAL STATUS

Briefly state the medical facts regarding the covered service member's health condition for which FMLA leave is requested:

_____

_____

Does the injury or illness render the covered service member medically unfit to perform the duties of his or her office, grade, rank or rating? _____ Yes _____ No

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

Approximate date condition commenced: _____

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

Is the covered service member undergoing medical treatment, recuperation, or therapy? ____Yes ____ No
If yes, please describe medical treatment, recuperation or therapy:
_____

_____

_____

COVERED SERVICE MEMBER'S NEED FOR CARE BY FAMILY MEMBER

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: _____

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

Is there a medical necessity for the covered service member to have periodic care for these follow-up treatment appointments? ____ Yes ____ No

Is there a medical necessity for the covered service member to have periodic care other than for scheduled follow-up treatment appointments (e.g., episodic flare-ups of medical condition)? This can include assisting in the covered service member's recovery. ____ Yes ____ No.
If yes, please estimate the frequency and duration of the periodic care: e.g. 2 times per month for 6 months lasting 3 days.
Frequency: _____ times per _____ week(s) _____ month(s).
Duration: _____ hour(s) or _____ day(s) per event.

Signature of
Health Care Provider _____ Date: _____