RUTGERS
University Human Resources

Certification for Serious Injury or Illness of Covered Servicemember for Military Family Leave Family and Medical Leave Act

SECTION I: Part A: Employee Information

INSTRUCTIONS to the EMPLOYEE and/or the Covered Servicemember for whom the Employee Is Requesting Leave: Please complete Section I of this form before giving it to the medical provider for completion of Section II. You must submit a timely, complete, and sufficient certification to support a request for FMLA leave due to a serious injury or illness of a covered servicemember. Your response is required to obtain or retain the benefit of FMLA-protected leave. Failure to do so may result in a denial of an employee's FMLA request. **You have 15 calendar days to return this form to your employer.**

EMPLOYEE:	First Name:	Middle Initial:	Last Name:

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

Parent means a biological, adoptive,step,or foster father or mother, or any other individual who stood *in loco parentis* to the employee or covered servicemember. It does not include parents-in-law.
Son or daughter in the context of military FMLA is given its common meaning and does not have an age or disability limitation.
Next of kin means the servicemember's nearest blood relative (other than the covered servicemember's spouse, parent, son, or daughter) in the following order of priority. An blood relative designated by servicemember, in writing, as next of kin for purposes of military caregiver leave under FMLA (in which case that person is deemed the sole next of kin). Blood relatives who have been granted legal custody of the servicemember by court decree or statutory provisions. Brothers and sisters, grandparents, aunts and uncles, and first cousins.

SECTION I: Part B: Covered Servicemember Information

SERVICEMEMBER:	First Name:	Middle Initial:	Last Name:

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

If yes, provide the military branch, rank and unit currently assigned to:

Is the covered servicemember 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 medical treatment facility or unit:

Is the servicemember on the Temporary Disability Retired List (TDRL)? ☐ Yes ☐ No

SECTION I - PART C: Care to Be Provided to the Covered Servicemember

Describe the care to be provided to the servicemember and an estimate of the leave needed to provide the care:

Employee Signature:	Date: / /

SECTION II - PART A: Health Care Provider Information

For Completion by a U.S. Dept. of Defense (DOD) health care provider or a health care provider who is either: (1) a U.S. Dept. 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.

INSTRUCTIONS to the HEALTH CARE PROVIDER: The employee listed above has requested leave under the FMLA to care for a family member 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 duty on active duty that may render the servicemember medically unfit to perform the duties of his or her office, grade, rank, or rating. A complete and sufficient certification to support a request for FMLA leave includes written documentation confirming that the covered servicemember's injury or illness was incurred in the line of duty on active duty. Also, that the covered servicemember is undergoing treatment for such injury or illness by a health care provider listed above. 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. Limit your responses to the condition for which the employee is seeking leave.

SECTION II - PART A: Health Care Provider Information (Continued)

Provider's Name:		
Provider's Business Address:		
Type of Practice/Medical Specialty:		
Please check whether you are:	☐ A DOD health care provider ☐ A VA health care provider ☐ A DOD TRICARE network authorized private health care provider ☐ A DOD non-network TRICARE authorized private health care provider	
Phone #:	Fax:	E-mail:

SECTION II - PART B: Medical Status

1. Covered servicemember'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. (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 FMLA. If such leave is requested, you may be required to complete DOL FORM WH-380 or an employer-provided form seeking the same information.)

2. Was the condition for which the Covered Service member is being treated incurred in line of duty on active duty (or existed before the beginning of the member's active duty and was aggravated by service in line of duty on active duty) in the armed forces within the past five years? ☐ 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? ☐ Yes ☐ No
   If yes, please describe medical treatment, recuperation or therapy:

SECTION II - 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 start and end dates for this period of time: Start: / / End: / /

2. Will the covered servicemember require periodic follow-up treatment appointments? ☐ Yes ☐ No
   If yes, estimate the treatment schedule:

3. Is the covered servicemember undergoing medical treatment, recuperation, or therapy? ☐ 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, please estimate the frequency and duration of the periodic care:

ADDITIONAL INFORMATION: (Identify question number with your additional answer.)

Signature of Health Care Provider:	Date: / /