Certification for Serious Injury or Illness of a Current Servicemember for Military Family Leave
(Family and Medical Leave Act)
U.S. Department of Labor
Wage and Hour Division

RETURN TO THE PATIENT - DO NOT SEND COMPLETED FORM TO THE DEPARTMENT OF LABOR.

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The Family and Medical Leave Act (FMLA) provides that eligible employees may take FMLA leave to care for a covered servicemember with a serious illness or injury. The FMLA permits an employer to require an employee seeking FMLA leave for this purpose to submit a medical certification. 29 U.S.C. §§ 2613, 2614(c)(3). The employer must give the employee **at least 15 calendar days**, absent unusual circumstances, to provide the certification. If the employee is unable to provide complete and sufficient certification, his or her FMLA leave request may be denied. 29 C.F.R. § 825.313. Information about the FMLA may be found on the WHD website at http://www.dol.gov/whd/fmla.

SECTION I - EMPLOYER

Please complete this section before giving the form to your employee.

(1) Employee name: ____
First *Middle* *Last*

(2) Employer name: ______________________________ Date: ____________________
(List date certification requested from the employee)

(3) On ________________ *(date)*, we learned of your need for leave beginning on ________________ *(date)* to care for a servicemember with an illness or injury.

(4) This certification must be returned no later than: ______________________________
*(List date certification is due, which must be at least **15 calendar days** from the date the certification is given to the employee)*

SECTION I - EMPLOYER INSTRUCTIONS

Please complete Section I before giving this form to your employee. Your response is voluntary. While you are not required to use this form, **you may not ask the employee to provide more information than allowed under the FMLA regulations, 29 C.F.R. § 825.310**. Information about the FMLA may be found on the WHD website at http://www.dol.gov/whd/fmla.

An employer requiring an employee to submit a certification for leave to care for a covered servicemember must accept as sufficient certification invitational travel orders (ITOs) or invitational travel authorizations (ITAs) issued to any family member to join an injured or ill servicemember at his or her bedside. An ITO or ITA is sufficient certification for the duration of time specified in the ITO or ITA.

Where medical certification is requested by an employer, an employee may not be held liable for administrative delays in the issuance of military documents, despite the employee's diligent, good-faith efforts to obtain such documents. Employers must generally maintain records and documents relating to medical information, medical certifications, recertifications, or medical histories of employees or employees' family members created for FMLA purposes as confidential medical records in separate files/records from the usual personnel files and in accordance with 29 C.F.R. § 1630.14(c)(1), if the Americans with Disabilities Act applies, and in accordance with 29 C.F.R. § 1635.9, if the Genetic Information Nondiscrimination Act applies.

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Employee Name: ____

SECTION II - EMPLOYEE and/or CURRENT SERVICEMEMBER

The FMLA allows an employer to require that an employee 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. If requested by the employer, your response is required to obtain or retain the benefit of FMLA-protected leave. The employer must give you **at least 15 calendar days** to return this form to the employer. 29 U.S.C. §§ 2613, 2614(c)(3). Failure to do so may result in a denial of the employee's request for FMLA leave. 29 C.F.R. § 825.310(f). Information about the FMLA may be found on the WHD website at http://www.dol.gov/whd/fmla.

Please complete all Parts of Section II before having the health care provider complete Section III.

PART A: EMPLOYEE INFORMATION

(1) Name of the current servicemember for whom employee is requesting leave:

____

First *Middle* *Last*

(2) Relationship of employee to the current servicemember:

(Select as appropriate)

☐ Spouse
☐ Parent, including *in loco parentis*
☐ Son or daughter of any age, including *in loco parentis*
☐ Next of Kin

("Next of kin" is the servicemember's nearest blood relative, other than the spouse, parent, son, or daughter, in the following order of priority: (1) a blood relative as designated in writing by the servicemember for purposes of FMLA leave, (2) blood relatives granted legal custody of the servicemember, (3) brothers and sisters, (4) grandparents, (5) aunts and uncles, and (6) first cousins.)

(*In loco parentis* refers to a relationship in which a person assumes the obligations of a parent to a child. This means that an employee may take FMLA leave to care for a covered servicemember who assumed the obligations of a parent to the employee when the employee was a child. An employee may also take FMLA leave to care for a covered servicemember for whom the employee has assumed the obligations of a parent.)

PART B: SERVICEMEMBER INFORMATION

(1) ☐ The servicemember is a current member of the Regular Armed Forces, the National Guard or Reserves. Provide the servicemember's military branch, rank and unit currently assigned to: ______________________________

____

(2) The servicemember is 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. Provide the name of the medical treatment facility or unit: ______________________________
☐ No

(3) The servicemember is on the Temporary Disability Retired List (TDRL):

☐ Yes
☐ No

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Employee Name: ____

PART C: CARE TO BE PROVIDED TO THE SERVICEMEMBER

(1) Briefly describe the care you will provide to your family member:

(Select as appropriate)

- ☐ Assistance with basic medical, hygienic, nutritional, or safety needs
- ☐ Transportation
- ☐ Physical Care
- ☐ Psychological Comfort
- ☐ Other: ____

(2) Give your best estimate of the amount of leave needed to provide the care described: ________________________

____

(3) If a reduced work schedule is necessary to provide the care described, give your **best estimate** of the reduced work schedule needed:

Starting date ______________________________ Ending date ________________________

Hour(s) per day ___________________________ Day(s) per week ______________________

SECTION III - HEALTH CARE PROVIDER

Please provide your contact information, complete all Parts of this Section fully and completely, and sign the form below. See page 5 for further instructions.

PART A: HEALTH CARE PROVIDER INFORMATION

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

Health Care Provider's business address: ____

Type of practice/Medical specialty: ____

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, or
- ☐ Health care provider as defined in 29 C.F.R. § 825.125

Telephone: ( ) ____ Fax: ( ) __________________________

E-mail address: ____

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Employee Name: ____

PART B: MEDICAL INFORMATION

Please provide appropriate medical information of the patient as requested below. 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.

(1) Patient's Name: ____

(2) List the approximate date condition started or will start: ______________________________

(3) Provide your **best estimate** of how long the condition will last: ______________________________

____

Limit your responses to the servicemember's condition for which the employee is seeking leave. 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). 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.

(4) The servicemember's injury or illness: *(Check one of the appropriate boxes)*

- ☐ 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.

(5) The servicemember:

- ☐ Is undergoing medical treatment, recuperation, or therapy for this condition. Briefly describe the medical treatment, recuperation or therapy: ______________________________
____
- ☐ Is not undergoing medical treatment, recuperation, or therapy for this condition.

(6) The current servicemember's medical condition is classified as:
(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 DOL FORM WH-380-F or an employer-provided form seeking the same information.*

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Employee Name: ____

PART C: AMOUNT OF LEAVE NEEDED

Please provide information concerning the amount of leave the employee will need to provide care for the servicemember.

(Select as appropriate)

☐ (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 and ending dates for this period of time:
____
____

☐ (2) Due to the condition, it is medically necessary for the servicemember to attend **planned medical treatment** appointments. Provide your **best estimate** of the treatment schedule, if any, including the date(s) of any scheduled appointment(s) and the time required for each appointment: ____________________________
____

☐ (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 long (the duration) and how often (the frequency) the intermittent episode(s) will last. *(e.g. 2 hours each episode, 1 time per week)*

Amount of Time (Duration)	**How Often (Frequency)**
________ Hour(s)	_______ per Day
________ Day(s)	_______ per week
________ Week(s)	_______ per Month
________ Month(s)	_______ per Year

Signature of
Health Care Provider ________________________________ **Date**__________________

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Employee Name: ______________________________

SECTION III - HEALTH CARE PROVIDER INSTRUCTIONS

The employee listed at 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.

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 member'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 his or her 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 is unable to transport him or herself 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. Information about the FMLA may be found on the WHD website at http://www.dol.gov/whd/fmla.

PAPERWORK REDUCTION ACT NOTICE AND PUBLIC BURDEN STATEMENT

If submitted, it is mandatory for employers to retain a copy of this disclosure in their records for three years, in accordance with 29 U.S.C. § 2616; 29 C.F.R. § 825.500. Persons are not required to respond to this collection of information unless it displays a currently valid OMB control number. The Department of Labor estimates that it will take an average of 15 minutes for respondents to complete this collection of information, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. If you have any comments regarding this burden estimate or any other aspect of this collection information, including suggestions for reducing this burden, send them to the Administrator, Wage and Hour Division, U.S. Department of Labor, Room S-3502, 200 Constitution Avenue, N.W., Washington, D.C. 20210.

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