FAMU | OFFICE OF HUMAN RESOURCES
FLORIDA AGRICULTURAL & MECHANICAL UNIVERSITY

Family and Medical Leave Act (FMLA)
Certification for Serious Injury or Illness Form of a Covered Service Member for Military Family Leave

Instructions for Employee: Please complete Section I before giving this form to covered service member or his/her health care provider. You are required to submit a timely, complete, and sufficient medical certification to support a request for FMLA leave. This form will provide the Office of Human Resources with information needed to determine if your leave request is for a qualifying reason under the FMLA. Failure to provide a complete and sufficient medical certification may result in a denial of your FMLA request. **This form should be returned within fifteen (15) calendar days of the request for this information.** If additional time is needed to complete and return the form, please contact the Office of Human Resources at (850) 599-3611 and request to speak with the FMLA Administrator. You will need to provide a reason for the delay and the date when the certification will be provided. You may return the form in person, by mail, or by fax. The fax number is (850) 412-5566. If sending by fax, please include a fax cover sheet marked "CONFIDENTAL" and address the fax to the Office of Human Resources.

SECTION I – EMPLOYEE INFORMATION

Name of Employee requesting leave to care for Covered Service Member:

Name of Covered Service Member:

Parent - A biological, adoptive, step or foster father or mother, or someone who stood *in loco parentis* to the employee or covered service member. For FMLA purposes, does not include in-laws.

Son or daughter – For military caregiver leave, son or daughter refers to a son or daughter of any age.

Next of kin - A blood relative designated by the service member 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). A blood relative that has been granted legal custody of the service member by court decree or statutory provisions. Brothers and sisters, grandparents, aunts and uncles, and first cousins.

Relationship of employee to Covered Service Member:

☐ Spouse ☐ Parent ☐ Son ☐ Daughter ☐ Next of Kin

PART A: COVERED SERVICE MEMBER INFORMATION

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

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

Military Branch: _____

Rank: _____

Unit: _____

2. Is the 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 medical treatment facility or unit:

_____

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

PART B: CARE TO BE PROVIDED TO THE COVERED SERVICE MEMBER

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

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I certify that the information that I provided above is true and correct.

Signature of Employee:	**Print Name**:	**Date**:

SECTION II – 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; or (4) a health care provider as defined in 29 CFR 825.125. Please ensure that the sections above have been completed before completing this section.

Instructions for Health Care Provider: The employee listed above has requested leave under the FMLA to care for a family member who is a current member of the Regular Armed Forces, 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 incurred in the line of duty while on active duty in the Armed Forces or that existed before the beginning of the service 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 service member 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 service member's injury or illness incurred in the line of duty while on active duty. Also, the covered service member is undergoing treatment for such injury or illness by a health care provider listed above. Please complete all applicable sections. 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. Please limit your responses to the condition for which the employee is seeking leave.

Provider's Name:		
Business Address:		
Type of Practice/Medical Specialty:		
Phone:	**Fax**:	**E-mail**:
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 TRICARE non-network TRICARE authorized private Health Care Provider** ☐ **Other health care provider**

PART A: MEDICAL STATUS

1. If you are unable to make certain 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). The service member's medical condition is classified as:

☐ **(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 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 FMLA. If such leave is requested, you may be required to complete an employer-provided form seeking the same information.)

2. Is the service member being treated for a condition which incurred in the line of duty on active duty or existed before the beginning of the active duty and was aggravated by service 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: From: _____ To: _____

5. Is the service member undergoing medical treatment, recuperation, or therapy? ☐ Yes ☐ No

6. If yes, please describe medical treatment, recuperation or therapy:

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PART B: COVERED SERVICE MEMBER'S NEED FOR CARE BY FAMILY MEMBER

1. Will the 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: From _____ To: _____

2. Will the service member require periodic follow-up treatment appointments? ☐ Yes ☐ No

If yes, estimate the treatment schedule: _____

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

4. Is there a medical necessity for the service member to have periodic care for other than scheduled follow-up treatment appointments (e.g., episodic flare-ups of medical condition)? ☐ Yes ☐ No

Frequency: _____ times per ☐ Week(s) ☐ Month(s) **Duration**: _____ hours or _____day(s) per episode

Flare ups may occur: From _____ Through _____

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

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Signature of Health Care Provider:	**Print Name:**	**Date**: