

## Serious Injury or Illness of a Servicemember Certification

Family & Medical Leave Act

AFSCME & PSSU

### SECTION 1: TO BE COMPLETED BY EMPLOYEE

**INSTRUCTIONS to the EMPLOYEE:** Please complete Section 1 before having Section 2 completed. The FMLA permits an employer to require that you submit a timely, complete, and sufficient medical certification to support a request for an absence that may qualify as FMLA leave (Military Caregiver Absence) due to a serious injury or illness of a servicemember. Your response is required to obtain or retain the benefit of FMLA and Military Caregiver Absence protections. Failure to provide a complete and sufficient medical certification may result in a denial of your FMLA and Military Caregiver Absence request. Section 2 of this form must be completed by the treating health care provider; it is inappropriate for it to be completed by anyone other than that provider. Note: If this is a request for leave for yourself or a family member with a serious health condition, you cannot use this form. Please obtain either: *Employee Serious Health Condition Certification* OR *Family Member Serious Health Condition Certification* from your Human Resource Office.

Employee Name	Personnel Number
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University	Work Location
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#### For Absences for Servicemembers, state the following:

Family Member / Patient Name	Relationship to Employee (spouse, parent, son, daughter, service member next of kin)
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Is the servicemember a current member of the regular Armed Forces, the National Guard or Reserves?  
 Yes     No

Military Branch	Rank	Unit If Currently Assigned
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Is the 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 the medical treatment facility or unit.

Is the covered servicemember on the Temporary Disability Retired List?  Yes     No

Describe the care you will provide to the covered servicemember

Estimate the amount of leave you will need to provide this care; include a schedule, if possible for intermittent absences.

### SECTION 2: TO BE COMPLETED BY HEALTH CARE PROVIDER:

**INSTRUCTIONS to the HEALTH CARE PROVIDER:** The health care provider must be a United States Department of Defense Health Care Provider or a Health Care Provider who is either a US Department of Veterans Affairs health care provider, a Department of Defense Tricare network authorized private health care provider, a Department of Defense non-network Tricare authorized private health care provider or a health care provider as defined in the FMLA. 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 or an injury or illness that existed before the beginning of the servicemember's active duty and was aggravated by service in the line of duty on active duty that may render a member of the Armed Forces (regular or reserve) medically unfit to perform the duties of his/her office, grade, rank, or rating.

A complete and sufficient certification to support a request for FMLA leave due to a servicemember's serious injury or illness includes written documentation confirming that the servicemember's injury or illness was incurred or aggravated in the line of duty on active duty and that the 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 on 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.

If you are unable to make certain of the military-related determinations contained below, you are permitted to rely upon determinations from an authorized Department of Defense representative (such as a recovery care coordinator). Please ensure the Section 1 above has been completed before completing this section. Please be sure to sign the form on the last page.

**Medical Status:**

Servicemember'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 illness/injury 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." If such leave is requested, you are required to complete the *Family Member Serious Health Condition Certification* form.)

1. Was the condition for which the servicemember is being treated incurred or aggravated in line of duty on active duty in the armed forces?  
 Yes  No
2. What is the approximate date the condition commenced?
3. What is the probable duration of the condition/incapacity and/or need for care?
4. Is the covered servicemember undergoing medical treatment, recuperation, or therapy?  Yes  No  
 If yes, please describe medical treatment, recuperation or therapy.

**Servicemember's Need for Care by Family Member:**

5. Will the servicemember need care for a single continuous period of time, including any time for treatment and recover?  
 Yes  No  
 If yes, estimate the beginning and ending dates for this period of time.
6. Will the servicemember require periodic follow-up treatment appointments?  Yes  No  
 If yes, estimate the treatment schedule.
7. Is there a medical necessity for the servicemember to have periodic care for these follow-up treatment appointments?  
 Yes  No
8. Is there a medical necessity for the servicemember to have periodic care for other than scheduled follow-up treatment appointments (example: episodic flare-ups of medical condition)?  Yes  No  
 If yes, please estimate the frequency and duration of the periodic care.

**By providing my original signature, the undersigned health care provider certifies that the information is true and accurate.**

Printed Name of Health Care Provider		Type of Practice/Medical Specialty	
Address		Telephone Number	
Name and Title of Person Completing the form, if not the Health Care Provider		Fax Number	
Please state whether you are a: <input type="checkbox"/> DOD health care provider <input type="checkbox"/> DOD TRICARE network authorized private health care provider <input type="checkbox"/> DOD non-network TRICARE authorized private health care provider <input type="checkbox"/> VA health care provider <input type="checkbox"/> Other health care provider			
Signature of Health Care Provider		Date	

**Return completed form to the employee or return it directly by mail or fax to**

Office of Human Resources, 1011 South Drive, Sutton Hall Room G-8, Indiana, PA 15705, (724)357-2431, (724)357-2685 (fax)