



CERTIFICATION FOR SERIOUS INJURY OR ILLNESS OF A CURRENT SERVICEMEMBER FOR MILITARY CAREGIVER LEAVE UNDER THE FAMILY AND MEDICAL LEAVE ACT	
DHR-Form #: To be assigned.	Authority: Family and Medical Leave Act of 1993, as amended February 25, 2015; M.R. 5.7
Effective Date: December 2, 2022	Supersedes: November 20, 2019; January 2009

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 allows 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** to provide the certification. If the employee fails 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 www.dol.gov/agencies/whd/fmla.

Part 1: Employer

Either the employee or the employer may complete Part 1. While use of this form is optional, it asks the health care provider for the information necessary for a complete and sufficient medical certification. **You may not ask the employee to provide more information than allowed under the FMLA regulations, 29 C.F.R. § 825.310. Recertifications are not allowed for FMLA leave to care for a covered servicemember. 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.** 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 the servicemember's bedside. An ITO or ITA is sufficient certification for the duration of time specified in the ITO or ITA.

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.

1. Employee name: _____
2. Agency Name: _____ Date: _____
(List date certification requested)
3. This medical certification must be returned by _____ *(Must allow at least 15 calendar days from the date requested, unless it is not feasible despite the employee's diligent, good faith efforts.)*

Part 2: Employee and/or Current Servicemember

Please complete all sections of Part 2 before having the servicemember's health care provider complete Part 3. 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 your employer, your response is required to obtain or retain the benefit of FMLA-protected leave.

Part A: Employee Information

1. Name of the current servicemember covered for whom the employee is requesting leave:

2. You are the current servicemember's: Spouse Parent Child Next of Kin

Part B: Service Member Information

3. The servicemember (is / is not) a current member of the Regular Armed Forces, the National Guard or Reserves. If yes, provide the servicemember's military branch, rank and unit currently assigned to: _____

4. The servicemember (is / is not) 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. If yes, provide the name of the medical treatment facility or unit:

5. The servicemember (is / is not) on the Temporary Disability Retired List (TDRL)

6. Briefly describe the care you will provide to the servicemember: (Check all that apply)

Assistance with basic medical, hygienic, nutritional, or safety needs

Psychological Comfort Physical Care Transportation

Other: _____

7. Give your **best estimate** of the amount of leave needed to provide the care described: _____

8. If a reduced work schedule is necessary to provide the care described, give your **best estimate** of the reduced work schedule you are able to work: From _____ to _____ I am able to work: ____ (hours/day) ____ (days per week).

Part 3: Health Care Provider

Please provide your contact information, complete all sections of this Part fully and completely, and sign the form below. The employee listed at Part 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. Note: 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 the servicemember’s 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 needs transportation to the doctor. It also includes providing psychological comfort and reassurance which would be beneficial to the servicemember who is receiving inpatient or homecare. 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.

Part A: Healthcare Provider Information

Health Care Provider’s Name: _____

Health Care Provider’s Business Address: _____

Type of Practice/Medical Specialty: _____

Telephone: _____ Fax: _____ Email: _____

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

Part B: Medical Information

Please provide appropriate medical information of the patient as requested below. Limit your responses to the servicemember’s condition for which the employee is seeking leave. 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. 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).

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: _____

4. The servicemember's injury or illness: (*Select as appropriate*)

- 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.
- None of the above

5. The servicemember (is / is not) undergoing medical treatment, recuperation, or therapy for this condition. If yes, briefly describe the medical treatment, recuperation or therapy:

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 DHR Certification for Family Member's Serious Health Condition under the FMLA Form.

Part C: Amount Of Leave Needed

For the medical condition checked in Part B, complete all that apply. Some 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.

7. 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 date _____ and end date _____ for this period of time.

8. Due to the condition, it is medically necessary for the servicemember to attend **planned medical treatment** appointments (scheduled medical visits). Provide your **best estimate** of the duration of the treatment(s), including any period(s) of recovery: _____
_____ (e.g., 3 days/week)

9. 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 often (frequency) and how long (duration) the intermittent episodes will likely last.

Over the next 6 months, intermittent care is estimated to occur: _____ times per
(day / week / month) and are likely to last approximately: _____ (hours / days)
per episode.

Signature of Health Care Provider: _____ **Date:** _____

By using this form, the parties acknowledge their agreement to conduct transactions by electronic means. A party's electronic signature for purpose of the Uniform Electronic Transactions Act, 6 Del. C. Ch. 12A may be provided by checking a box as indicated, electronic initials or name, or email confirmation.

Paperwork Reduction Act 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 20 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 AV, NW, Washington, DC 20210. **DO NOT SEND THE COMPLETED FORM TO THE WAGE AND HOUR DIVISION; RETURN IT TO THE PATIENT.**