Delaware Department of Human Resources

CERTIFICATION OF SERIOUS INJURY OR ILLNESS OF A VETERAN 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 March 8, 2013; 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 veteran 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 I. While use of this form is optional, it asks the healthcare provider for the information necessary for a complete and sufficient medical certification. **Recertifications are not allowed for FMLA leave to care for a covered service member. 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.** In lieu of this form or your own certification form, you must accept as sufficient certification of the veteran's serious injury or illness documentation indicating the veteran's enrollment in the Department of Veteran's Affairs Program of Comprehensive Assistance for Family Caregivers. **You may not ask the employee to provide more information than allowed under the FMLA regulations, 29 C.F.R. § 825.310.**

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 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 Veteran

Please complete all sections of Part 2 before having the veteran's healthcare 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 military caregiver leave under the FMLA due to a serious injury or illness of a covered veteran. If requested by your employer, your response is required to obtain or retain the benefit of FMLA-protected leave. The employer must give an employee **at least 15 calendar days** to return this form to the employer. 29 U.S.C. §§ 2613, 2614(c)(3).

Part A: Employee Information

1. Name of veteran for whom the employee is requesting leave:

   _____

2. You are the current servicemember's:

   ☐ Spouse ☐ Parent ☐ Child ☐ Next of Kin

Part B: Veteran Information and Care to be Provided to the Veteran

3. The veteran was (☐ honorably / ☐ dishonorably) discharged or released from the Armed Forces, including the National Guard or Reserves. List the date of the veteran's discharge:

   _____

4. Please provide the veteran's military branch, rank, and unit at the time of discharge:

   _____

5. The veteran (☐ is / ☐ is not) receiving medical treatment, recuperation, or therapy for an injury or illness.

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

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

   ☐ Psychological comfort ☐ Physical Care ☐ Other: _____

7. Give your **best estimate** of the amount of FMLA 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 named in Part I has requested leave under the military caregiver leave provision of the FMLA to care for a family member who is a veteran.

Note: For purposes of FMLA military caregiver leave, a serious injury or illness means an injury or illness incurred by the servicemember in the line of duty on active duty in the Armed Forces (or that 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 manifested itself before or after the servicemember became a veteran, and is: a continuation of a serious injury or illness that was incurred or aggravated when the covered veteran was a member of the Armed Forces and rendered the servicemember unable to perform the duties of the servicemember's office, grade, rank, or rating; or a physical or mental condition for which the covered veteran has received a U.S. Department of Veterans Affairs Service Related Disability Rating (VASRD) of 50% or greater, and such VASRD rating is based, in whole or in part, on the condition precipitating the need for military caregiver leave; or a physical or mental condition that substantially impairs the covered veteran's ability to secure or follow a substantially gainful occupation by reason of a disability or disabilities related to military service, or would do so absent treatment; or an injury, including psychological injury, on the basis of which the covered veteran has been enrolled in the Department of Veterans' Affairs Program of Comprehensive Assistance for Family Caregivers.

"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 veteran 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 veteran who is receiving inpatient or home care.

A complete and sufficient certification to support a request for FMLA military caregiver leave due to a covered veteran's serious injury or illness includes written documentation confirming that the veteran's injury or illness was incurred in the line of duty on active duty or existed before the beginning of the veteran's active duty and was aggravated by service in the line of duty on active duty, and that the veteran is undergoing treatment, recuperation, or therapy for such injury or illness by a health care provider listed above. Information about the FMLA may be found on the WHD website at www.dol.gov/agencies/whd/fmla.

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 veteran's condition for which the employee is seeking leave. If you are unable to make certain military-related determinations contained below, you are permitted to rely upon determinations from an authorized DOD representative, such as a DOD Recovery Care Coordinator, or an authorized VA representative. 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 veteran'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

The veteran (☐ is /☐ is not) undergoing medical treatment, recuperation, or therapy for this condition.

If yes, briefly describe the medical treatment, recuperation, or therapy:_____

_____

_____

_____

5. The veteran's medical condition is: (Select as appropriate)
   - ☐ A continuation of a serious injury or illness that was incurred or aggravated when the covered veteran was a member of the Armed Forces and rendered the servicemember not able to perform the duties of the servicemember's office, grade, rank, or rating.
   - ☐ A physical or mental condition for which the covered veteran has received a U.S. Department of Veterans Affairs Service Related Disability Rating (VASRD) of 50% or higher, and such VASRD rating is based, in whole or in part, on the condition precipitating the need for military caregiver leave.

- ☐ A physical or mental condition that substantially impairs the covered veteran's ability to secure or follow a substantially gainful occupation by reason of a disability or disabilities related to military service, or would do so absent treatment
- ☐ An injury, including a psychological injury, on the basis of which the covered veteran is enrolled in the Department of Veterans' Affairs Program of Comprehensive Assistance for Family Caregivers.
- ☐ 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 seeking the same information.*

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 military caregiver leave coverage.

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

2. Due to the condition, it is medically necessary for the veteran 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*)

3. Due to the condition, it is medically necessary for the veteran 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 veteran'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 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 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.**