

# CERTIFICATION BY SERVICE MEMBER'S HEALTH CARE PROVIDER FOR CAREGIVER MILITARY FAMILY LEAVE – FMLA

**SECTION I: For completion by the EMPLOYEE and/or the COVERED SERVICE MEMBER for whom the Employee is requesting leave (This section must be completed before any of the below sections can be completed by a health care provider.)**

Name of Employee Requesting Leave to Care for Covered Service member:

Name of Covered Service Member (for whom employee is requesting leave to care):

Relationship of Employee to Covered Service Member:

Spouse  Parent  Son  Daughter  Next of Kin

Is the Covered Service Member a Current Member of the Regular Armed Forces, the National Guard or Reserves?  Yes  No

If yes, please provide the covered service member's military branch, rank and unit currently assigned to:

Is the covered 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 the medical treatment facility or unit: \_\_\_\_\_

Is the covered service member on the Temporary Disability Retired List (TDRL)?  Yes  No

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

**SECTION II: For completion by a United States Department of Defense ("DOD") Health Care Provider or a Health Care Provider who is either (1) a United States Department 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. If you are unable to make certain of the military-related determinations contained below in Part B, you are permitted to rely upon determinations from an authorized DOD representative (such as a DOD recovery care coordinator). (Please ensure that Section I above has been completed before completing this section.) Please be sure to sign the form on the last page.**

Health Care Provider's Name (Please print): \_\_\_\_\_

Health Care Provider's Signature: \_\_\_\_\_

Date: \_\_\_\_\_

Address: \_\_\_\_\_

Phone number: \_\_\_\_\_

Fax number: \_\_\_\_\_

Specialty/Type of Practice: \_\_\_\_\_

Please state whether you are either: (1) a DOD health care provider; (2) a VA health care provider; (3) a DOD TRICARE network authorized private health care provider; or (4) a DOD non-network TRICARE authorized health care provider: \_\_\_\_\_

**MEDICAL STATUS**

Briefly state the medical facts regarding the covered service member's health condition for which FMLA leave is requested:

\_\_\_\_\_  
\_\_\_\_\_

Does the injury or illness render the covered service member medically unfit to perform the duties of his or her office, grade, rank or rating? \_\_\_\_ Yes \_\_\_\_ No

Was the condition for which the covered service member is being treated incurred in line of duty on active duty in the armed forces? \_\_\_\_ Yes \_\_\_\_ No

Approximate date condition commenced: \_\_\_\_\_

Probable duration of condition and/or need for care: \_\_\_\_\_

Is the covered service member undergoing medical treatment, recuperation, or therapy? \_\_\_\_ Yes \_\_\_\_ No  
If yes, please describe medical treatment, recuperation or therapy:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**COVERED SERVICE MEMBER'S NEED FOR CARE BY FAMILY MEMBER**

Will the covered 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: \_\_\_\_\_

Will the covered service member require periodic follow-up treatment appointments? \_\_\_\_ Yes \_\_\_\_ No

If yes, estimate the treatment schedule: \_\_\_\_\_

Is there a medical necessity for the covered service member to have periodic care for these follow-up treatment appointments? \_\_\_\_ Yes \_\_\_\_ No

Is there a medical necessity for the covered service member to have periodic care other than for scheduled follow-up treatment appointments (e.g., episodic flare-ups of medical condition)? This can include assisting in the covered service member's recovery. \_\_\_\_ Yes \_\_\_\_ No.

If yes, please estimate the frequency and duration of the periodic care: e.g. 2 times per month for 6 months lasting 3 days.

Frequency: \_\_\_\_\_ times per \_\_\_\_\_ week(s) \_\_\_\_\_ month(s).

Duration: \_\_\_\_\_ hour(s) or \_\_\_\_\_ day(s) per event.

Signature of Health Care Provider \_\_\_\_\_ Date: \_\_\_\_\_