

Certification for Serious Injury or Illness
of Covered Servicemember
(Family and Medical Leave Act)



EMPLOYEE NAME: _____ EMPLOYEE ID/SSN: _____

CASE NUMBER: _____ EMPLOYER NAME: _____

INSTRUCTIONS to the EMPLOYEE or COVERED SERVICEMEMBER

The FMLA permits 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. Your response is required to obtain or retain the benefit of FMLA-protected leave. 29 U.S.C. §§ 2613, 2614(c)(3). Failure to do so may result in a denial of an employee's FMLA request. 29 C.F.R. § 825.310(f). The employer must give an employee at least 15 calendar days to return this form to the employer.

Return a complete and sufficient certification to:

Sedgwick CMS
P.O. Box 9830
Calabasas, CA 91372-0830
Fax: 818-591-7664

COVERED SERVICEMEMBER INFORMATION

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

First Middle Last

Relationship of Employee to Covered Servicemember Requesting Leave to Care:

Spouse Father Mother Son Daughter Next of Kin Other: _____

(1) Is the Covered Servicemember a Current Member of the Regular Armed Forces, the National Guard, or Reserves?
____ Yes ____ No

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

Is the covered 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:

(2) Is the Covered Servicemember on the Temporary Disability Retired List (TDRL)? ____ Yes ____ No

CARE TO BE PROVIDED TO THE COVERED SERVICEMEMBER

Describe the care to be provided to the covered servicemember and an estimate of the leave needed to provide the care:

INSTRUCTIONS for 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 INSTRUCTIONS to the HEALTH CARE PROVIDER:

The employee listed has requested leave under the FMLA to care for a family member who is a 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. For purposes of FMLA leave, a serious injury or illness is one that was incurred in the line of duty on active duty that may render the servicemember 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 due to a covered servicemember’s serious injury or illness includes written documentation confirming that the covered servicemember’s injury or illness was incurred in the line of duty on active duty and that the covered 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 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. 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 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 the section above has been completed before completing this section.) Please be sure to sign the form on the last page.

Part A: HEALTH CARE PROVIDER INFORMATION

Health Care Provider’s Name and Business Address:

Type of Practice/Medical Specialty:

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 private health care provider.

Telephone: () _____ Fax: () _____ Email: _____

PART B: MEDICAL STATUS

- (1) Covered Servicemember’s medical condition is classified as (Check One of the Appropriate Boxes):
- (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 § 825.113 of the FMLA. If such leave is requested, you may be required to complete DOL FORM WH-380 or an employer-provided form seeking the same information.)
- (2) Was the condition for which the Covered Servicemember is being treated incurred in 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: _____
- (5) Is the covered servicemember undergoing medical treatment, recuperation, or therapy? ____ Yes ____ No. If yes, please describe medical treatment, recuperation or therapy:

PART C: COVERED SERVICEMEMBER’S NEED FOR CARE BY FAMILY MEMBER

- (1) Will the covered servicemember 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:

- (2) Will the covered servicemember require periodic follow-up treatment appointments? ____ Yes ____ No
If yes, estimate the treatment schedule: _____
- (3) Is there a medical necessity for the covered servicemember to have periodic care for these follow-up treatment appointments? ____ Yes ____ No
- (4) Is there a medical necessity for the covered servicemember to have periodic care for other than scheduled follow-up treatment appointments (e.g., episodic flare-ups of medical condition)? ____ Yes ____ No
If yes, please estimate the frequency and duration of the periodic care:

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