



**CERTIFICATION FOR SERIOUS INJURY OR ILLNESS  
OF COVERED SERVICEMEMBER**  
**Federal Family and Medical Leave Act (FMLA)**  
**Military Caregiver Leave**

**Section I. Employee and or the Covered Servicemember (for whom the employee is requesting leave to provide care) Completes this Section**

**Instructions to the employee or covered servicemember:** Complete Section I before having Section II completed. The FMLA permits the agency to require 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 the agency, your response is required to obtain or retain the benefit of FMLA-protected leave per 29 U.S.C. §§ 2613, 2614(c)(3). Failure to do so may result in a denial of your FMLA request per 29 C.F.R. § 825.310(f). Please return this form to the agency within 15 calendar days.

**Part A: Employee Information**

Name and address of employee's agency: (this is the agency of the employee requesting leave to care for a covered servicemember)

\_\_\_\_\_

Name of employee requesting leave to care for a Covered Servicemember:

\_\_\_\_\_

(first)

(middle)

(last)

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

\_\_\_\_\_

(first)

(middle)

(last)

Relationship of employee to Covered Servicemember: (Please check one)

spouse     parent     son     daughter     next of kin

**Part B: Covered Servicemember Information**

1. Is the covered servicemember a member of the Regular Armed Forces, the National Guard or the 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

**Part C: 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: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**Section II. Health Care Provider (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 private health care provider) Completes this Section**

**Instructions to the health care provider:** The employee listed above 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 must include 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 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 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 Section II.) Please sign the form on the last page.

**Part A: Health Care Provider Information**

Health Care Provider's Name and Business Address: \_\_\_\_\_  
\_\_\_\_\_

Type of Practice or Medical Specialty: \_\_\_\_\_

Please mark whether you are:  a DOD health care provider,  a VA health care provider,  a DOD TRICARE network authorized private health care provider; or  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 or Injured** – Illness or 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 or Injured** – Illness or 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 Illness or Injury** – 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 submit a different health care certification as directed by the agency.)

(2) Was the condition for which the Covered Servicemember is being treated incurred in the 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 appointment (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 Signed:** \_\_\_\_\_

**Return this form to the covered servicemember.**

**You may instead, return the form to the family member providing care, or fax to the attention of  
Oregon Department of Fish & Wildlife  
Human Resources  
Fax #503/947-6050 (marked CONFIDENTIAL)**