



Certification for Serious Injury or Illness of Covered Service Member for Military Family Leave

Family and Medical Leave Act

Medina County Human Resources
144 North Broadway, Room 206
Medina, Ohio 44256



Notice to the APPOINTING AUTHORITY: Pursuant to Policy 4.010, Family and Medical Leave, Medina County requires an employee seeking FMLA leave due to a serious injury or illness of a covered servicemember to submit a certification providing sufficient facts to support the request for leave. Please complete Section I before giving this form to your employee. You may not require the employee to provide more information than what this form asks. Records created for FMLA purposes relating to medical certifications, re-certifications, or medical histories must be maintained as confidential medical records in separate files from the usual personnel files.

SECTION I: For completion by the EMPLOYEE and/or the COVERED SERVICEMEMBER for whom the employee is requesting leave.

INSTRUCTIONS to the EMPLOYEE or COVERED SERVICEMEMBER: Please complete Section I before having Section II completed. Medina County Policy, 4.010, requires that you submit a timely, complete, and sufficient certification to support your request for FMLA leave due to a serious injury or illness of a covered servicemember. Failure to provide this information may result in denial of your leave request and protections provided under the FMLA. You will be given at least 15 calendar days to return this form.

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 INSTRUCTIONS to the HEALTH CARE PROVIDER: The employee listed on Page 2 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 herein. 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. Please limit your responses to the condition for which the employee is seeking leave.

CONTINUED ON NEXT PAGE

Employee: _____

SECTION I: For Completion by the EMPLOYEE and/or the COVERED SERVICEMEMBER for whom the employee is requesting leave: (This section must be completed first before any of the sections below can be completed by a health care provider.)

Part A: EMPLOYEE INFORMATION

Name and address of appointing authority (this is the appointing authority of the employee requesting leave to care for covered servicemember):

First MI Last

Address

City State Zip

Name of employee requesting leave to care for covered servicemember::

First MI Last

Name of covered servicemember (for whom employee is requesting leave to care for):

First MI Last

Relationship of employee to covered servicemember requesting leave to care for:

- Spouse Parent Son Daughter Next of Kin

Part B: COVERED SERVICEMEMBER INFORMATION

- (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

- (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:

CONTINUED ON NEXT PAGE

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.

PART A: HEALTH CARE PROVIDER INFORMATION

Health care provider’s name and business address:

Provider’s Name: _____

Address: _____ City: _____ State: ____ Zip: _____

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 Medina County’s FMLA policy. If such leave is requested, you will be required to complete Form WH-380.)

(2) 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

(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:

CONTINUED ON NEXT PAGE

Employee: _____

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

PLEASE NOTE: Original to employee; send completed copy to Human Resources & retain copy for department records.