Sheridan School District 48J

Code: **GCBDA/GDBDA-AR(3)(D)**
Revised/Reviewed: 1/20/10; 3/21/12; 6/19/13

Military Family Leave

Certification for Serious Injury or Illness of Covered Servicemember for Military Family Leave

Notice and instructions to the district:

The Family Medical Leave Act (FMLA) provides that a district may require 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. Employees may not be asked to provide more information than allowed under the FMLA regulations 29 C.F.R. § 825.310. The district will maintain records and documents relating to medical certification, recertifications or medical histories of employees or employees' family member, created for FMLA purposes, as confidential medical records in separate files from personnel files and in accordance with 29 C.F.R. § 1630.14(c)(1), if the Americans with Disabilities Act applies.

Section 1

Part A: Employee information

Complete the employee and covered servicemember information below before giving this form to your family member or his/her medical provider.

_____

District name and address

Name of employee requesting leave to care for covered servicemember:

_____

First Middle Last

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

_____

First Middle Last

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

□ Spouse □ Parent □ ~~Son~~ Child ~~□ Daughter~~ □ Next of kin

Part B: Covered Servicemember Information

1. Is the covered servicemember a current member of the regular ~~a~~Armed ~~f~~Forces, the National Guard or Reserves, or a veteran? □ Yes □ No

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

   _____

   _____

   If a qualifying veteran, when was the date of discharge? _____
   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 medical hold or warrior transition unit)? □ Yes □ No

If yes, provide the name of the medical 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 2:

~~**To be completed by a health care provider as defined by FMLA regulations.**~~(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; (3) a DOD non-network TRICARE authorized private health care provider; or (4) a health care provider as defined in 29 C.F.R. § 825.125.)

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 1 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 speciality: _____

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; (4) a DOD non-network TRICARE authorized private care provider; or (5) a health care provider as defined in 29 C.F.R. § 825.125.

_____

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 the 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." If such leave is requested, you may be required to complete the form *Certification of Health Care Provider for Family Member's Serious Health Condition.*)

2. Was the condition for which the covered servicemember is being treated incurred in the line of duty on active duty in the ~~a~~Armed ~~f~~Forces? □ Yes □ No

   If no, did the condition exist before the beginning of active duty and aggravated by service in the line of duty while on active duty? □ Yes □ No

3. Appropriate 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 servicemember to have periodic care for these follow-up treatment appointment? □ 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 conditions)? □ Yes □ No
   If yes, estimate the frequency and duration of the periodic care.

   _____

_____ _____
Signature of Health Care Provider Date

Corrected 5/08/17