# FAMILY AND MEDICAL LEAVES
# CERTIFICATION OF HEALTH CARE PROVIDER
# (CURRENT SERVICEMEMBER/COVERED VETERAN)

Pursuant to the federal Family and Medical Leave Act (FMLA), the purpose of this form is to provide sufficient facts to support a request for military family leave due to a serious injury or illness of a current servicemember or covered veteran; also known as "Military Caregiver Leave." (Note: This leave may also be covered under the California Family Rights Act (CFRA).

For Employee, Current Servicemember and/or Covered Veteran for whom the employee is requesting leave: Please complete Section I (Parts A, B & C) of this form. Be as specific as possible; terms such as "unknown," or indefinite," may not be sufficient to determine FMLA coverage and may result in a denial of your leave request. Submission of a timely, completed and sufficient certification to support a request for FMLA leave due to a serious injury or illness of a current servicemember or covered veteran is required to obtain the FMLA benefit. You must return the required certification to your Human Resources Office/Disability Coordinator within 15 days.

For Health Care Provider: The employee listed below (Section 1) has requested leave under the FMLA (military caregiver leave provision) to care for a family member who is a current servicemember or covered veteran of the Armed Forces with a serious injury or illness as defined by the FMLA and National Defense Authorization Act of 2010. Please answer fully and completely all applicable parts in Section II (Parts D – E). 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 military caregiver leave coverage. Limit your responses to the servicemember'/veteran's condition for which the employee is seeking leave.

For a current servicemember: To care for a family member who is a current servicemember 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 (a serious injury or illness is one that was incurred in the line of duty on active duty in the Armed Forces or that existed before the beginning of the member's active duty and was aggravated by service in the line of duty on active duty in the Armed Forces that may render the servicemember medically unfit to perform the duties of his or her office, grade, rank, or rating).

For a covered veteran: To care for a family member who is a covered veteran with a serious injury or illness incurred by the veteran in the line of duty on active duty in the Armed Forces (or that existed before the beginning of the veteran's active duty and was aggravated by service in the line of duty on active duty in the Armed Forces) and manifested itself before or after the servicemember became a veteran.

IMPORTANT: The Genetic Information Nondiscrimination Act of 2008 (CalGINA) prohibits employers and other entities covered by CalGINA Title II from requesting or requiring genetic information of an individual or family member of the individual, except as specifically allowed by this law. To comply with this law, we are asking that you not provide any genetic information when responding to this request for medical information. 'Genetic information' as defined by CalGINA, includes an individual's family medical history, the results of an individual's or family member's genetic tests, the fact that an individual or an individual's family member sought or received genetic services, and genetic information of a fetus carried by an individual or an individual's family member or an embryo lawfully held by an individual or family member receiving assistive reproductive services.

## SECTION I –
## TO BE COMPLETED BY EMPLOYEE/SERVICEMEMEBER/VETERAN (PARTS A, B & C)

### EMPLOYEE INFORMATION (PART A)

Employee's Name: _____ Employee's ID #: _____

Agency/Department: _____

Name of Current Servicemember: _____

Name of Covered Veteran: _____

Relationship: □ Spouse □ Parent □ Son □ Daughter □ Next of Kin

(Please specify Next of Kin Relationship): _____

## SECTION I – (Con't)
## TO BE COMPLETED BY EMPLOYEE/SERVICEMEMEBER/VETERAN (PARTS A, B & C)

### CURRENT SERVICEMEMBER INFORMATION (PART B)

1. Is the **current servicemember** a current member of the regular Armed Forces, the National Guard or Reserves? □ Yes □ No
   - If yes, provide the servicemember's military branch, rank and unit currently assigned to: _____

2. Is the **current 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? □ Yes □ No
   - If yes, provide the name of the medical treatment facility/unit: _____

3. Is the **current servicemember** on the Temporary Disability Retired List (TDRL)? □ Yes □ No

### COVERED VETERAN INFORMATION

4. Date of the **covered veteran's** discharge:_____

5. Was the **covered veteran** dishonorably discharged or released from the Armed Forces (including the National Guard or Reserves)? □ Yes □ No

6. Provide the **covered veteran's** military branch, rank and unit at the time of discharge: _____

7. Is the veteran receiving medical treatment, recuperation, or therapy for an injury/illness? □ Yes □ No

### TYPE OF CARE TO BE PROVIDED TO THE SERVICEMEMBER/VETERAN (PART C)

1. Describe the care to be provided to the □ **current servicemember** *or* □ **covered veteran** and an estimate of the leave needed to provide care:

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# SECTION II – TO BE COMPLETED BY HEALTH CARE PROVIDER (PARTS D & E)

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, or (4) a health care provider as defined in 29 CFR 825.125. Note: If you are unable to make certain of the military-related determinations contained in Part B, you are permitted to rely upon determinations from an authorized DOD representative (such as, DOD Recovery Care Coordinator) or an authorized VA representative. Please ensure that Section I - (Parts A, B & C) have been completed before completing the Health Care Provider section.

INSTRUCTIONS FOR HEALTH PROVIDER – CURRENT SERVICEMEMBER OR COVERED VETERAN:
A complete and sufficient certification to support a request for FMLA leave due to a current servicemember's/covered veteran's serious injury or illness includes written documentation confirming that 1) the servicemember's injury or illness was incurred in the line of duty on active duty or if not, that the servicemember's injury or illness existed before the beginning of the servicemember's active duty and was aggravated by service in the line of duty on active duty in the Armed Forces, and that the servicemember is undergoing treatment for such injury or illness by a health care provider listed above, or 2) the covered veteran's injury or illness was incurred in the line of duty on active duty or existed before the beginning of the veteran's active duty and was aggravated by service in the line of duty on active duty, and that the veteran is undergoing treatment, recuperation, or therapy 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. Please limit your responses to the servicemember's/veteran's condition for which the employee is seeking leave.

## MEDICAL STATUS OF THE CURRENT SERVICEMEMBER (PART D)

1. The current servicemember's medical condition is classified as (check appropriate box):

- □ (VSI) Very Seriously Illness/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 obtain a completed Alameda County's Certification of Health Care Provider (Employee/Family Member) (FML Form 2)

2. Is the current servicemember being treated for a condition which was incurred or aggravated by service in the 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: _____.

3. Is the current servicemember undergoing medical treatment, recuperation, or therapy for this condition? □ Yes □ No
   - If yes, please describe medical treatment, recuperation or therapy:

_____

## MEDICAL STATUS OF THE COVERED VETERAN

1. The covered veteran's medical condition is (check appropriate box):

- □ A continuation of a serious injury/illness that was incurred or aggravated when the covered veteran was a member of the Armed Forces and rendered the servicemember unable to perform the duties of the servicemember's office, grade, rank, or rating.
- □ A physical or mental condition for which the covered veteran has received a US Department of Veterans Affairs Service Related Disability Rating (VSDRD) of 50% or higher, and such VASRD rating is based, in whole or in part, on the condition precipitating the need for military caregiver leave.
- □ A physical or mental condition that substantially impairs the covered veteran's ability to secure or follow a substantially gainful occupation by reason of a disability or disabilities related to military service, or would do so absent treatment.
- □ An injury, including a psychological injury, on the basis of which the covered veteran is enrolled in the Department of Veterans' Affairs Program of Comprehensive Assistance for Family Caregivers.
- □ 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 obtain a completed Alameda County's Certification of Health Care Provider (Employee/Family Member) (FML Form 2)

3. Is the covered veteran being treated for a condition which was incurred or aggravated by service in the line of duty on active duty in the Armed Forces? □ Yes □ No

## SECTION II – Con't
## TO BE COMPLETED BY HEALTH CARE PROVIDER (PART E)

### CURRENT SERVICEMEMBER'S/COVERED VETERAN'S NEED FOR CARE BY FAMILY MEMBER (PART E)

1. Will the servicemember/veteran 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 servicemember/veteran require periodic follow-up treatment appointments? □ Yes □ No If yes, estimate the treatment schedule:
   _____

3. Is there a medical necessity for the servicemember/veteran to have periodic care for these follow-up treatment appointments? □ Yes □ No

4. Is there a medical necessity for the servicemember/veteran to have periodic care 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:
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### HEALTH CARE PROVIDER INFORMATION

_____

**Health Care Provider's Name** **Address**

_____

**Type of Practice/Medical Specialty** **Telephone & Fax Number**

**Please indicate if you are a:**

1. □ **DOD health care provider**
2. □ **VA health care provider**
3. □ **DOD TRICARE network authorized private health care provider**
4. □ **DOD non-network TRICARE authorized private health care provider, or**
5. □ **A health care provider as defined in 29 CFR 825.125**

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**Signature of Health Care Provider** **Date**