FAMILY AND MEDICAL LEAVE ACT
Certification for Serious Injury or Illness of Covered Servicemember -- for Military Family Leave

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 below sections can be completed by a health care provider.)

Part A: EMPLOYEE INFORMATION

Name of Employee Requesting Leave to Care for Covered Servicemember:

_____

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

_____

Relationship of Employee to Covered Servicemember Requesting Leave to Care:
_____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, Reserves, or is a Veteran who was a member in the Armed Forces any time during the 5 years preceding the date on which the Veteran underwent medical treatment, therapy or recuperation? _____ 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: 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.

The Genetic Information Nondiscrimination Act of 2008 (GINA) prohibits employers and other entities covered by GINA Title II from requesting or requiring genetic information of employees or their family members. In order 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 GINA, 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.

Please note that information about the health condition of your patient may be provided as needed to complete the certification request.

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 Number: _____ Fax Number _____

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.)

NOTE: Serious injury or illness is expanded to include something that existed before the covered servicemember's active duty and was aggravated by service in line of duty on active duty. For Veterans the serious illness or injury may manifest itself before or after the member becomes a veteran.

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:

_____

_____

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: _____

_____

Name of Health Care Provider: _____

Signature of Health Care Provider: _____

Date: _____

RETURN COMPLETED FORM TO:
City of Tacoma, Human Resources
747 Market Street #1420
Tacoma, WA 98402
FAX – 253-591-5451

To request this information in an alternative format, please contact Human Resources at 253-591-5452 or Washington Relay 711.