STATE OF WEST VIRGINIA
FEDERAL FAMILY and MEDICAL LEAVE ACT (FMLA)
Certification for Serious Injury or Illness of
Covered Servicemember (for Military Family Leave)

Notice to the EMPLOYER INSTRUCTIONS to the EMPLOYER: The federal Family and Medical Leave Act (FMLA) provides that an employer 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. Your response is voluntary. While you are not required to use this form, you may not ask the employee to provide more information than allowed under the FMLA regulations, 29 C.F.R. §825.310. Employers must generally maintain records and documents relating to medical certifications, recertifications, or medical histories of employees or employees' family members, created for FMLA purposes as confidential medical records in separate files/records from the usual personnel files and in accordance with 29 C.F.R. §1630.14(c)(1), if the Americans with Disabilities Act applies.

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. The FMLA permits an employer to require that 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 employer, your response is required to obtain or retain the benefit of FMLA-protected leave. 29 U.S.C. §§2613, 2614(c)(3). Failure to do so may result in a denial of an employee's FMLA request. 29 C.F.R. §825.310(f). The employer must give an employee at least 15 calendar days to return this form to the employer.

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 (or former member during the past 5 years) 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 service member's serious injury or illness includes written documentation confirming that the covered service member'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 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. Limit your responses to the condition for which the employee is seeking leave.

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 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 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. Family medical history is required only to the extent necessary to make the medical certification complete and sufficient under FMLA.

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 and Address of Employer (this is the employer of the employee requesting leave to care for covered servicemember):

Employer Name: _____

Employer 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):

_____

First Middle Last

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 or Reserves? ☐ No ☐ Yes

If yes, please provide the covered service member's military branch, rank and unit currently assigned to:

RANK: **BRANCH and UNIT:** _____

Is the Covered servicemember a veteran who is undergoing medical treatment, recuperation, or therapy, for a serious injury or illness as designated by the Secretary of Labor that was incurred by the member in line of duty on active duty in the Armed Forces (or existed before the beginning of the member's active duty and was aggravated by service in line of duty on active duty in the Armed Forces) and who was a member of the Armed Forces (including a member of the National Guard or Reserves) at any time during the period of 5 years preceding the date on which the veteran undergoes that medical treatment, recuperation, or therapy? ☐ No ☐ Yes

If yes, please provide the covered service member's military branch, rank and unit previously assigned to:

RANK: **BRANCH and UNIT:** _____

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)?

☐ No ☐ Yes 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)?
☐ No ☐ Yes

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.

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: (_____) _____ Fax: (_____) _____ Email: _____

PART B: MEDICAL STATUS

(1) Covered service member's medical condition is classified as (Check Appropriate Box):

- ☐ **(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 service member 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.)

(2) Was the condition for which the Covered servicemember is being treated incurred in line of duty on active duty in the armed forces? ☐ No ☐ Yes

(3) Approximate date condition commenced: _____

(4) Probable duration of condition and/or need for care (required): _____

_____

_____

(5) Is the covered service member undergoing medical treatment, recuperation, or therapy?
☐ No ☐ Yes If yes, please describe medical treatment, recuperation or therapy:

_____

_____

_____

_____

_____

PART C: COVERED SERVICE MEMBER'S NEED FOR CARE BY FAMILY MEMBER

(1) Will the covered service member need care for a single continuous period of time, including any time for treatment and recovery? ☐ No ☐ Yes If yes, estimate the beginning and ending dates for this period of time:_____

(2) Will the covered servicemember require periodic follow-up treatment appointments?
☐ No ☐ Yes If yes, estimate the treatment schedule: _____

_____

_____

_____

_____

(3) Is there a medical necessity for the covered service member to have periodic care for these follow-up treatment appointments? ☐ No ☐ Yes

(4) Is there a medical necessity for the covered service member to have periodic care for other than scheduled follow-up treatment appointments (e.g., episodic flare-ups of medical condition)?
☐ No ☐ Yes If yes, please estimate the frequency and duration of the periodic care:

_____

_____

_____

_____

_____ _____
Signature of Health Care Provider Date