FAMILY AND MEDICAL LEAVE
CERTIFICATION OF SERIOUS ILLNESS OR INJURY
FOR A COVERED SERVICEMEMBER

TO BE COMPLETED BY THE EMPLOYEE REQUESTING LEAVE

1. Employee requesting leave: ____

2. Name of covered servicemember: ___________________________________.

3. Relationship of employee to covered servicemember (check the appropriate box):

   ☐ Spouse
   ☐ Parent
   ☐ Son/Daughter
   ☐ Next-of-kin (please specify relationship:____________________); or
   ☐ None of the above.

4. Is the covered servicemember currently a 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 the unit to which the servicemember is assigned:

   ____

   ____

5. 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:

   ____

6. Is the covered servicemember on the Temporary Disability Retired List (TDRL)? ☐ Yes ☐ No

7. Describe the care to be provided to the covered servicemember and an estimate of the amount of leave needed to provide this care:

   ____

   ____

   ____

   ____

TO BE COMPLETED BY THE COVERED SERVICEMEMBER'S HEALTH CARE PROVIDER

I, ________________________________, confirm that I am a (please check one):
(Name of Health Care Provider)

☐ DOD health care provider;
☐ VA health care provider;
☐ DOD TRICARE network authorized health care provider; or
☐ DOD non-network TRICARE authorized private health care provider.

1. I certify that I have been or will be providing care to the covered servicemember identified on the first page of this certification.

2. The covered servicemember's medical condition meets one of the following DOD classifications:

   ☐ **(VSI) Very Seriously Injured –** Illness/injury of such a severity that life is imminently endangered. Family members are requested at bedside immediately.

   ☐ **(SI) Seriously Ill/Injured –** Illness/injury of such a severity that there is cause for immediate concern, but there is no imminent danger to life. Family members are requested at bedside.

   ☐ **OTHER Ill/Injured –** Serious illness or injury which may render servicemember medically unfit to perform duties of servicemember's office, grade, rank, or rating.

   ☐ **NONE OF THE ABOVE**.

3. Was the condition for which the covered service member is being treated incurred in the line of duty while on active duty in the armed forces? ☐ Yes ☐ No

4. What is the approximate date the condition commenced? ____________________________________

5. What is the probably duration of the condition and/or the foreseeable time the servicemember will need care from a medical provider or family member? ____

6. Is the covered servicemember currently undergoing medical treatment, recuperation, or therapy?

   ☐ Yes ☐ No

   If yes, please describe the medical treatment, recuperation, or therapy:

   ____

   ____

   ____

7. Will the covered servicemember need care for a single continuous period of time, including any time for treatment and recovery? ☐ Yes ☐ No

   If yes, please estimate the beginning and ending dates of this period of time:

   ____

8. Will the covered servicemember require periodic follow-up treatment/appointments? ☐ Yes ☐ No

If yes, please estimate the servicemember's treatment schedule (dates and times): ____________________

____

Is there a medical necessity for the employee to accompany or care for the covered servicemember in connection with these follow-up treatment appointments? ☐ Yes ☐ No

If yes, please describe the care to be provided and the leave necessary to provide that care: ____________

____

____

9. Is the servicemember's condition likely to cause episodic flare-ups? ☐ Yes ☐ No

Is the employee needed to care for the servicemember during these flare-ups? ☐ Yes ☐ No

If yes, please estimate the frequency of flare-ups and the duration of any leave needed to care for the servicemember (e.g., 1 episode every 3 months lasting 1-2 days):

Frequency:______times per _______ week(s) ________month(s)

Duration:_______hours or _______ day(s) per episode

Dated this ______________________________ day of ________________, 20___.

____ ______________________________

Signature of Health Care Provider Telephone Number

____ ______________________________

Address City/State

Email:__________________________________

Fax:____________________________________