CERTIFICATION OF HEALTH CARE PROVIDER FOR MILITARY CAREGIVER LEAVE – SERVICEMEMBER

(*FAMILY AND MEDICAL LEAVE – AM-203-2-7*)

Section I: To be Completed by the Employee

Employee's Full Name ____________________ Job Title ____________________

Agency/Bureau/Division ____________________

Regular Work Schedule ____________________

Phone ____________________ Email ____________________

Name of servicemember for whom care will be provided ____________________

The servicemember is the employee's:

☐ Parent ☐ Spouse ☐ Child ☐ Next of kin (specify):____________________

Is the servicemember a current member of the Regular Armed Forces, the National Guard or Reserves?...... ☐ Yes ☐ No

If yes, provide military branch, rank and unit ____________________

Is the 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:

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

Describe the care you will provide to the servicemember and estimate the amount of leave necessary to provide such care:

I affirm that, to the best of my knowledge, the above information contains no false or misleading statements.

Employee Signature ____________________ Date ____________________

(*Form continues*)

Section II: To Be Completed by the Health Care Provider

For completion by a United States Department of Defense (DOD) Health Care Provider or a Health Care Provider who is: 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.

The employee named in Section I has requested leave under the *Family and Medical Leave Act* (FMLA) to care for your patient. In order for the leave request to be approved, the employee must provide a complete and sufficient certification.

Please answer the questions in this certification form fully and completely. Make sure to sign the last page. Several questions ask you to describe the frequency or duration of a condition, treatment, etc. You should provide your best estimate, based upon your medical knowledge, experience and examination of the patient. Please 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 servicemember's condition for which the employee is seeking leave.

______________________________ ______________________________
Health Care Provider's Name   Name of Practice/Health Care Facility

____
Business Address

____
Type of Practice/Specialty

______________________________ ______________________________
Phone   Fax

Indicate whether the provider is:

☐ DOD health care provider

☐ VA health care provider

☐ DOD TRICARE network authorized private health care provider

☐ DOD non-network TRICARE authorized private health care provider

☐ A health care provider as defined in 29 C.F.R. §825.125

Section II, Part A: Medical Status

If you are unable to make certain military-related determinations described below, you may rely upon determinations from an authorized DOD representative (such as a DOD recovery care coordinator).

The servicemember's medical condition is classified as (check one):

☐ **(VSI) Very Seriously Ill/Injured**: Illness/injury is of such a severity that life is imminently endangered. Family members are requested at bedside immediately (*NOTE: this is an internal DOD casualty assistance designation used by DOD health care 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 (*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: If this box is checked, employee may still be eligible to take FMLA leave for the care of a family member with a "serious health condition." Employee should contact a human resources representative to request the appropriate certification form.

Was the condition for which the servicemember is being treated incurred in the line of duty while on active duty in the Armed Forces? ☐ Yes ☐ No

Approximate Date Condition Commenced

Probable Duration of Condition and/or Need for Care

Is the covered servicemember undergoing medical treatment, recuperation or therapy? ☐ Yes ☐ No

If yes, describe medical treatment, recuperation or therapy:

Section II, Part B: Servicemember's Need for Care By Family Member

The term "care" refers to both physical and psychological care. It includes situations where, for example, the servicemember is unable to care for his or her own basic medical, hygienic or nutritional needs or safety or is unable to transport him or herself to the doctor. It also includes providing psychological comfort and reassurance that would be beneficial to the servicemember who is receiving inpatient or home care.

Will the servicemember need care for a single, continuous period of time due to his/her condition, including any time for treatment and recovery? ☐ Yes ☐ No

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

Beginning Date

Ending Date

Will the servicemember require periodic follow-up treatment or appointments? ☐ Yes ☐ No

If yes, estimate the treatment schedule, including the dates or frequency of any scheduled appointments and the time required for each appointment, including any recovery period:

Is there a medical necessity for the servicemember to have periodic care for these follow-ups? ☐ Yes ☐ No

Is there a medical necessity for the servicemember to have periodic care for other than scheduled follow-up treatment or appointments? ☐ Yes ☐ No
(*e.g. episodic flare-ups of medical condition*)

If yes, estimate the frequency and duration of periodic care:

Section III: Health Care Provider Verification

Signature of Health Care Provider

Date