



**CERTIFICATION FOR SERIOUS INJURY OR ILLNESS OF A VETERAN FOR  
MILITARY CAREGIVER LEAVE  
(Family and Medical Leave Act)**

**SECTION I: EMPLOYER**

**Employer Name and Address:** City of Bryan – 300 South Texas Ave., Bryan, TX 77803  
**Employer Contact:** Teresa McGinnis, HR Generalist  
979-209-5063 (phone), 1-800-604-9664 (fax) or [tmcginnis@bryantx.gov](mailto:tmcginnis@bryantx.gov) (email)

**SECTION II: EMPLOYEE & CURRENT SERVICEMEMBER**

Please complete this section before giving the form to your health care provider. The FMLA permits an employer to require that you submit a timely, complete, and sufficient certification to support a request for military caregiver leave under the FMLA leave due to a serious injury or illness of a covered veteran. Your response is required to obtain or retain the benefit of FMLA-protected leave. Failure to do so may result in a denial of your request for FMLA leave. Your employer must give you at least 15 calendar days to return this form.

**PART A: EMPLOYEE INFORMATION**

**Employee Name** (First, Middle, Last): \_\_\_\_\_  
**Name of Veteran Receiving Care:** (First, Middle, Last): \_\_\_\_\_  
**Relationship of Employee to Veteran Receiving Care:**  Spouse  Parent  Son  Daughter  Next of Kin

**PART B: VETERAN INFORMATION**

1. Is the Servicemember a Current Member of the Regular Armed Forces, the National Guard or Reserves?  
 No  Yes  
a. If yes, please provide the servicemember's military branch, rank and unit currently assigned to:  
\_\_\_\_\_
2. 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)?  No  Yes  
a. If yes, please provide the name of the medical treatment facility or unit: \_\_\_\_\_
3. Is the Servicemember on the Temporary Disability Retired List (TDRL)?  No  Yes

**PART C: CARE TO BE PROVIDED**

Describe the Care to Be Provided to the Veteran and an Estimate of the Leave Needed to Provide the Care: \_\_\_\_\_  
\_\_\_\_\_

**SECTION III: 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.

The employee listed under Section II has requested leave under the military caregiver leave provision of the FMLA to care for a family member who is a veteran. For purposes of FMLA military caregiver leave, a serious injury or illness means an injury or illness incurred by the servicemember in the line of duty on active duty in the Armed Forces (or that 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 manifested itself before or after the servicemember became a veteran, and is:

- (i) a continuation of a serious injury or 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; or
- (ii) a physical or mental condition for which the covered veteran has received a U.S. Department of Veterans Affairs Service Related Disability Rating (VASRD) of 50 percent or greater, and such VASRD rating is based, in whole or in part, on the condition precipitating the need for military caregiver leave; or
- (iii) a physical or mental condition that substantially impairs the covered veteran's ability to secure or follow a



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substantially gainful occupation by reason of a disability or disabilities related to military service, or would do so absent treatment; or

(iv) an injury, including a psychological injury, on the basis of which the covered veteran has been enrolled in the Department of Veterans' Affairs Program of Comprehensive Assistance for Family Caregivers.

A complete and sufficient certification to support a request for FMLA military caregiver leave due to a covered veteran's serious injury or illness includes written documentation confirming that the 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 military caregiver leave coverage. Limit your responses to the veteran's condition for which the employee is seeking leave.

Please ensure that Section II 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**

**Provider's Name and Business Address:** \_\_\_\_\_

**Type of Practice / Medical Specialty:** \_\_\_\_\_

**Telephone:** \_\_\_\_\_ **Fax:** \_\_\_\_\_ **Email:** \_\_\_\_\_

**Please Indicate Whether You Are:** (1) a DOD health care provider; (2) a VA health care provider; (3) a DOD TRICARE network authorized private health care provider; (4) a DOD non-network TRICARE authorized private health care provider, or (5) other health care provider:

### **PART B: MEDICAL STATUS**

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.

1. Veteran's medical condition is:
  - A continuation of a serious injury or 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 U.S. Department of Veterans Affairs Service Related Disability Rating (VASRD) 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
2. Is the 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?  No  Yes
3. Approximate date condition commenced: \_\_\_\_\_



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- 4. Probable duration of condition and/or need for care: \_\_\_\_\_
- 5. Is the veteran undergoing medical treatment, recuperation, or therapy for this condition?  No  Yes
  - a. If yes, please describe medical treatment, recuperation or therapy: \_\_\_\_\_

**PART C: VETERAN'S NEED FOR CARE BY FAMILY MEMBER**

"Need for care" encompasses both physical and psychological care. It includes situations where, for example, due to his or her serious injury or illness, the veteran 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 which would be beneficial to the veteran who is receiving inpatient or home care.

- 1. Will the veteran need care for a single continuous period of time, including any time for treatment and recovery?  
 No  Yes
  - a. If yes, estimate the beginning and ending dates for this period of time: \_\_\_\_\_
- 2. Will the veteran require periodic follow-up treatment appointments?  No  Yes
  - a. If yes, estimate the treatment schedule: \_\_\_\_\_
- 3. Is there a medical necessity for the veteran to have periodic care for these follow-up treatment appointments?  
 No  Yes
- 4. Is there a medical necessity for the veteran to have periodic care for other than scheduled follow-up treatment appointments (e.g. episodic flare-ups of medical condition)?  No  Yes
  - a. If yes, please estimate the frequency and duration of the periodic care: \_\_\_\_\_

\_\_\_\_\_  
**Signature of Health Care Provider**

\_\_\_\_\_  
**Date**