



**CERTIFICATION FOR SERIOUS INJURY OR ILLNESS OF CURRENT SERVICEMEMBER FOR
MILITARY FAMILY 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 (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 FMLA leave due to a serious injury or illness of a servicemember. 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 Current Servicemember Receiving Care: (First, Middle, Last): _____
Relationship of Employee to Current Servicemember Receiving Care: Spouse Parent Son Daughter
 Next of Kin

PART B: CURRENT SERVICEMEMBER 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 Current Servicemember 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 FMLA to care for a family member who is a member 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 in the Armed Forces or that existed before the beginning of the member's active duty and was aggravated by service in the line of duty on active duty in the Armed Forces 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 current servicemember's serious injury or illness includes written documentation confirming that the servicemember's injury or illness was incurred in the



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line of duty on active duty or if not, that the current servicemember's injury or illness 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 that the current servicemember is undergoing treatment for such injury or illness by a health care provider listed above. Please 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.

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 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: _____

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, or (5) a health care provider as defined in 29 CFR 825.125:

PART B: MEDICAL STATUS

1. Current 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.)

2. Is the current Servicemember 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: _____

4. Probable duration of condition and/or need for care: _____

5. Is the servicemember undergoing medical treatment, recuperation, or therapy? No Yes

a. If yes, please describe medical treatment, recuperation or therapy: _____

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



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1. Will the servicemember 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 servicemember require periodic follow-up treatment appointments? No Yes
 - a. If yes, estimate the treatment schedule: _____
3. Is there a medical necessity for the servicemember to have periodic care for these follow-up treatment appointments? No Yes
4. Is there a medical necessity for the servicemember 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