

Certification for Serious Injury or
Illness of a Current
Servicemember - -for Military Family Leave
(Family and Medical Leave Act)

U.S. Department of Labor

Wage and Hour Division

OMB Control Number: 1235-0003
Expires: 5/ 1/2018

Notice to the EMPLOYER

SECTION I: For Completion by the EMPLOYEE and/or the CURRENT 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 the current servicemember):

Name of Employee Requesting Leave to Care for the Current Servicemember:

First

Middle

Last

Name of the Current Servicemember (for whom employee is requesting leave to care):

First

Middle

Last

Relationship of Employee to the Current Servicemember:

Spouse Parent Son Daughter Next of Kin

Part B: SERVICEMEMBER INFORMATION

(1) Is the Servicemember a Current Member of the Regular Armed Forces, the National Guard or Reserves?
Yes No

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

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

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; (3) a DOD non-network TRICARE authorized private health care provider; or (4) a health care provider as defined in 29 CFR 825.125. 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

(5) Is the servicemember undergoing medical treatment, recuperation, or therapy for this condition? Yes No

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

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

(1) Will the servicemember need care for a single continuous period of time, including any time for treatment and recovery? Yes No

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

(2) Will the servicemember require periodic follow-up treatment appointments? Yes No

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? Yes No

(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)?
Yes No

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

Signature of Health Care Provider: _____ **Date:** _____

PAPERWORK REDUCTION ACT NOTICE AND PUBLIC BURDEN STATEMENT

If submitted, it is mandatory for employers to retain a copy of this disclosure in their records for three years, in accordance with 29 U.S.C. 2616; 29 CFR 825.500. Persons are not required to respond to this collection of information unless it displays a currently valid OMB control number.