

STATE OF OHIO
**Certification for Serious Injury or Illness
Of Covered Servicemember
(FAMILY AND MEDICAL LEAVE ACT)**

CONFIDENTIAL
(Please Print or Type)

SECTION I: For Completion by the EMPLOYEE or COVERED SERVICEMEMBER

Instructions: Please complete Section I before having Section II completed. The FMLA permits an employer to require that an employee submit a timely, complete, and sufficient certification to support a request for FMLA leave due to a serious injury or illness of a covered servicemember. If requested by the employer, 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 FMLA request. Your agency must give you at least 15 calendar days to return this form.

Part A: Employee Information

Agency Name (this is the agency of the employee requesting leave to care for the covered servicemember) :

Name of Employee Requesting Leave to Care for Covered Servicemember: _____

OAKS User ID: _____

Telephone (W): _____ Telephone (H): _____

Address: _____

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

Relationship of Employee to Covered Servicemember Requesting Leave to Care:

Spouse Parent Son Daughter Next of Kin

Part B: Covered Servicemember Information

- 1) Is the covered servicemember a current 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 unit currently assigned to:

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: _____

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

Part C: Care to be Provided to the Covered Servicemember

Describe the care to be provided to the covered servicemember and an estimate of the leave needed to provide the care: _____

SECTION II: For Completion by the US Department of Defense (DOD) health care provider, a US Department of Veterans Affairs health care provider, a DOD Tricare network authorized private health care provider, or a DOD non-network Tricare authorized private health care provider.

Instructions: *The employee identified above 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 Reserves who is undergoing medical treatment, recuperation, or therapy, is otherwise in outpatient status, or is otherwise on the temporary disability retire 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 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 covered servicemember's serious injury or illness includes written documentation confirming that the covered servicemember's injury or illness was incurred in the line of duty on active duty and that the covered servicemember is undergoing treatment 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 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.

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 of Practice/Medical Specialty: _____

Please state whether you are either:

- A DOD health care provider
- A VA health care provider
- A DOD TRICARE network authorized private health care provider, or
- DOD non-network TRICARE authorized private health care provider.

Telephone: (____) _____ Fax: (____) _____ Email: _____

Part B: Medical Status

1. Covered 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.)
2. Was the condition for which the Covered Service member is being treated incurred in the line of duty on active duty in the armed forces? ___ Yes ___ No.
3. Approximate date condition commenced: _____
4. Probable duration of condition and/or need for care: _____
5. Is the covered servicemember undergoing medical treatment, recuperation or therapy? ___ Yes ___ No. If yes, please describe medical treatment, recuperation or therapy: _____

Part C: Covered Servicemember’s Need for Care by Family Member

1. Will the covered 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 covered servicemember require periodic follow-up treatment appointments? ___ Yes ___ No. If yes, estimate the treatment schedule: _____

3. Is there a medical necessity for the covered servicemember to have period care for these follow-up treatment appointments? ___ Yes ___ No
4. Is there a medical necessity for the covered servicemember to have period 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

ATTENTION SUPERVISORS: Completed form shall be placed in the confidential section of the employee’s personnel file. This form is for official use only. The information contained herein should **not** be shared with other employees except to the extent needed to make appropriate administrative decisions. Failure to maintain confidentiality of the information reported on this form may be grounds for appropriate corrective action.