Reset Form

Certification for Current Servicemember
Caregiver Leave under the FMLA

STATE OF MAINE
All Executive Branch Employees

SECTION I – EMPLOYER

Employee Name	Employee ID (*e.g.* TAMS ID)	Department
HR Representative Name	**HR Representative Phone**	**HR Representative Fax**
HR Representative Email		
Date Certification Provided to Employee	**Certification Due Date**	

SECTION II – FOR COMPLETION BY THE EMPLOYEE

Name of Current Servicemember

Relationship to the Employee

☐ Spouse ☐ Domestic Partner ☐ Parent ☐ Child (Any Age) ☐ Next of Kin

Select the Appropriate Description:

☐ The servicemember is a current member of the Regular Armed Forces, the National Guard, or Reserves. Provide the servicemember's military branch, rank, and unit currently assigned to:

_____

☐ The servicemember is 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. Provide the name of the medical treatment facility or unit:

_____

☐ The Service member is on the Temporary Disability Retired List (TDRL).

Briefly Describe the care you will provide to the servicemember (Check all that Apply):

☐ Assistance with basic medical, hygienic, nutritional, or safety needs ☐ Transportation

☐ Psychological Comfort ☐ Physical Care ☐ Other: _____

Give your best estimate of the amount of leave needed to provide the care described above:

_____

_____

Reduced Schedule. If a reduced schedule is needed to provide care, give your best estimate of the reduced schedule you are able to work:

From: _____ To: _____

I am able to work: _____

(e.g., 5 hours/day, up to 25 hours a week)

SECTION III – FOR COMPLETION BY THE HEALTH CAREPROVIDER

Please complete all Parts of this Section fully and completely and sign the form below. The employee listed at Section I has requested leave under the FMLA to care for a family member who is a current 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.

Note: 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 the servicemember's office, grade, rank, or rating.

"Need for care" includes both physical and psychological care. It includes situations where, for example, due to their serious injury or illness, the servicemember is not able to care for their own basic medical, hygienic, or nutritional needs or safety, or needs transportation to the doctor. It also includes providing psychological comfort and reassurance which would be beneficial to the servicemember who is receiving inpatient or home care.

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 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.

PART A: PROVIDER INFORMATION

Provider's Name	Type of Medical Practice / Medical Specialty

Business Address

Phone	Fax

Please select the type of FMLA healthcare provider you are:

- ☐ DOD Healthcare Provider
- ☐ VA Healthcare Provider
- ☐ Health care provider as defined in 29 CFR § 825.125
- ☐ DOD TRICARE network authorized private health care provider
- ☐ DOD non-network TRICARE authorized private health care provider

PART B: MEDICAL FACTS

Please provide appropriate medical information of the patient as requested below. Limit your responses to the servicemember's condition for which the employee is seeking leave. If you are unable to make some of the military-related determinations contained below, you are permitted to rely upon determinations from an authorized DOD representative, such as a DOD recovery care coordinator. Do not provide information about genetic tests, as defined in 29 C.F.R. § 1635.3(f), or genetic services, as defined in 29 C.F.R. §1635.3(e).

Servicemember's Name	
Approximate Date Condition Commenced	Probable Duration of the Condition

The servicemember's injury or illness: *(Select as appropriate)*

- ☐ Was incurred in the line of duty on active-duty.
- ☐ Existed before the beginning of the servicemember's active-duty and was aggravated by service in the line of duty on active-duty.
- ☐ None of the above.

Is the servicemember undergoing medical treatment, recuperation, or therapy for this condition?

☐ Yes ☐ No

If yes, briefly describe the medical treatment, recuperation or therapy:

_____

_____

_____

The current servicemember's medical condition is classified as: *(Select as appropriate)*

- ☐ **(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.*
- ☐ **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 29 C.F.R. § 825.113 of the FMLA. If such leave is requested, you may be required to complete a Certification of Healthcare Provider for Family Member's Serious Health Condition.*

PART C: AMOUNT OF LEAVE NEEDED

For the medical condition checked in Part B, complete all that apply. Some 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.

Check all that Apply:

☐ **Continuous Leave.** Due to the condition, the servicemember was or will be incapacitated for a continuous period of time, including any time for treatment(s) and/or recovery.

From: _____ To: _____

☐ **Planned Medical Appointments.** Due to the condition, the patient will have planned medical appointments on the following dates:

_____

☐ **Intermittent Leave.** Due to the condition, it is medically necessary for the employee to be absent from work on a periodic basis to provide care to the patient, including for any episodes of incapacity *i.e.*, episodic flare-ups. Provide your best estimate of how often (frequency) and how long (duration) the episodes of incapacity will likely last.

Over the next 6 months, absences on an **intermittent basis** are estimated to occur:

_____ ☐ Day / ☐ Week / ☐ Month and are likely to last approximately

_____ ☐ hours / ☐ days per episode.

PART D: ADDITIONAL INFORMATION

_____

_____

_____

_____

_____

PART E: SIGNATURE

_____ _____

Signature of Health Care Provider Date

_____

Printed Name and Title