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 Veteran

Relationship to the Employee

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

The veteran's discharge or release from the Armed Forces, including the National Guard or Reserves was:

☐ Honorable ☐ Dishonorable

The date the veteran was discharged was: ________________________________

The veteran's military branch, rank, and unit at the time of discharge:

____

Is the veteran receiving medical treatment recuperation or therapy for an injury or illness?

☐ Yes ☐ No

Briefly Describe the care you will provide to the veteran (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)

EMPLOYEE LAST NAME:___________________________

SECTION III – FOR COMPLETION BY THE HEALTH CAREPROVIDER

Please complete all Parts of this Section fully and completely and sign the form below.

Note: For purposes of FMLA military caregiver leave, a serious injury or illness means an injury or illness incurred by the veteran in the line of duty on active-duty in the Armed Forces (or that existed before the beginning of the veteran'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 veteran became a veteran, and 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 veteran unable to perform the duties of the veteran's office, grade, rank, or rating; or 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 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; or 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.

"Need for care" includes both physical and psychological care. It includes situations where, for example, due to their serious injury or illness, the veteran 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 veteran who is receiving inpatient or home care.

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 with a health care provider.

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

EMPLOYEE LAST NAME:___________________________

PART B: MEDICAL FACTS

Please provide appropriate medical information of the veteran as requested below. Limit your responses to the veteran's condition for which the employee is seeking leave. If you are unable to make certain military-related determinations contained below, you are permitted to rely upon determinations from an authorized DOD representative, such as a DOD Recovery Care Coordinator, or an authorized VA representative. 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).

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

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

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

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

☐ Yes ☐ No

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

____

____

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

- ☐ 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 not able 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.
- ☐ 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.
- ☐ 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.** *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.*

EMPLOYEE LAST NAME:____________________________

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 veteran. 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 veteran 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 veteran 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 veteran, 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

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PART E: SIGNATURE

____ ______________________________

Signature of Health Care Provider Date

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Printed Name and Title