Certification for Serious Injury or Illness of a Veteran for Military Caregiver Leave under the Family and Medical Leave Policy for Employees of Maine State Government

SECTION I – EMPLOYER

Either the employee or the employer may complete Section I. While use of this form is optional, it asks the health care provider for the information necessary for a complete and sufficient medical certification. Recertifications are not allowed for FMLA leave to care for a covered servicemember. Where medical certification is requested by an employer, an employee may not be held liable for administrative delays in the issuance of military documents, despite the employee's diligent, good-faith efforts to obtain such documents. In lieu of this form or your own certification form, you must accept as sufficient certification of the veteran's serious injury or illness documentation indicating the veteran's enrollment in the Department of Veterans Affairs Program of Comprehensive Assistance for Family Caregivers. You may not ask the employee to provide more information than allowed under the FMLA regulations, 29 C.F.R. § 825.310.

Employers must generally maintain records and documents relating to medical information, medical certifications, recertifications, or medical histories of employees or employees' family members, created for FMLA purposes as confidential medical records in separate files/records from the usual personnel files and in accordance with 29 C.F.R. § 1630.14(c)(1), if the Americans with Disabilities Act applies, and in accordance with 29 C.F.R. § 1635.9, if the Genetic Information Nondiscrimination Act applies.

(1) Employee name: ____

(2) Employer name: ________________________ Date: ________________ (mm/dd/yyyy)

(3) This certification must be returned by: ____________________________ (mm/dd/yyyy)
(Must allow at least 15 calendar days from the date requested, unless it is not feasible despite the employee's diligent, good faith efforts.)

SECTION II –EMPLOYEE and/or VETERAN

Please complete all Parts in Section II before having the veteran's health care provider complete Section III. The FMLA allows an employer to require that an employee submit a timely, complete, and sufficient certification to support a request for military caregiver leave under the FMLA due to a serious injury or illness of a covered veteran. If requested by the employer, your response is required to obtain or retain the benefit of FMLA-protected leave. The employer must give an employee **at least 15 calendar days** to return this form to the employer. 29 U.S.C. §§ 2613, 2614(c)(3).

PART A: EMPLOYEE INFORMATION

(1) Name of the veteran for whom employee is requesting leave:

____

First *Middle* *Last*

(2) Select your relationship to the veteran. You are the veteran's:

Spouse   Parent   Child   Next of Kin

Spouse means a husband or wife as defined or recognized in the state where the individual was married, including a common law marriage or same-sex marriage. The terms "child" and "parent" include in loco parentis relationships in which a person assumes the obligations of a parent to a child. An employee may take FMLA leave to care for a covered servicemember who assumed the obligations of a parent to the employee when the employee was a child. An employee may also take FMLA leave to care for a covered servicemember for whom the employee has assumed the obligations of a parent. No biological or legal relationship is necessary. "Next of kin" is the servicemember's nearest blood relative, other than the spouse, parent, son, or daughter, in the following order of priority: (1) a blood relative as designated in writing by the servicemember for purposes of FMLA leave, (2) blood relatives granted legal custody of the servicemember, (3) brothers and sisters, (4) grandparents, (5) aunts and uncles, and (6) first cousins.

PART B: VETERAN INFORMATION AND CARE TO BE PROVIDED TO THE VETERAN

(3) The veteran was (honorably / dishonorably) discharged or released from the Armed Forces, including the National Guard or Reserves. List the date of the veteran's discharge: ________________________________ (mm/dd/yyyy)

(4) Please provide the veteran's military branch, rank and unit at the time of discharge: ____

(5) The veteran (is / is not) receiving medical treatment, recuperation, or therapy for an injury or illness.

(6) Briefly describe the care you will provide to the veteran (Check all that apply):

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

Psychological Comfort   Physical Care

Transportation   Other:________________

(7) Give your **best estimate** of the amount of leave needed to provide the care described: ____

(8) If a reduced work schedule is necessary to provide the care described, give your best estimate of the reduced work schedule you are able to work. From _________________ (mm/dd/yyyy) to ____________________ (mm/dd/yyyy), I am able to work: _______________ (hours per day) ______________________________ (days per week).

SECTION III - HEALTH CARE PROVIDER

Please provide your contact information, complete all Parts of this Section fully and completely, and sign the form below. The employee named in Section I has requested leave under the military caregiver leave provision of the FMLA to care for a family member who is a veteran.
Note: For purposes of FMLA military caregiver leave, a serious injury or illness means an injury or illness incurred by the servicemember in the line of duty on active duty in the Armed Forces (or that 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 manifested itself before or after the servicemember 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 servicemember unable to perform the duties of the servicemember'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 his or her serious injury or illness, the veteran is not able to care for his or her 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 by a health care provider listed above. Information about the FMLA may be found on the WHD website at www.dol.gov/agencies/whd/fmla.

PART A: HEALTH CARE PROVIDER INFORMATION

Health Care Provider's Name: (Print) ____
Health Care Provider's business address: ____
Type of practice/Medical specialty: ____
Telephone: (___) _____________ Fax: (___) _____________ E-mail: _____________________

Please select the type of FMLA health care provider you are:

DOD health care provider

VA health care provider

DOD TRICARE network authorized private health care provider

DOD non-network TRICARE authorized private health care provider

Health care provider as defined in 29 C.F.R. § 825.125

PART B: MEDICAL INFORMATION

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, or 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).

(1) Patient's Name: ____

(2) List the approximate date condition started or will start: _______________ (mm/dd/yyyy)

(3) Provide your **best estimate** of how long the condition will last: _____________________

(4) 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.

The veteran (is / is not) undergoing medical treatment, recuperation, or therapy for this condition.

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

(5) The 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.

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.

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 DOL FORM WH-380-F or an employer-provided form seeking the same information.

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.

(7) Due to the condition, the veteran will need care for a **continuous period of time**, including any time for treatment and recovery. Provide your **best estimate** of the beginning date ________________ (mm/dd/yyyy) and end date _____________ (mm/dd/yyyy) for this period of time.

(8) Due to the condition, it is medically necessary for the veteran to attend **planned medical treatment** appointments (scheduled medical visits). Provide your **best estimate** of the duration of the treatment(s), including any period(s) of recovery ____ (e.g. 3 days/week)

(9) Due to the condition, it is medically necessary for the veteran to receive care on an **intermittent basis** (periodically), such as the care needed because of episodic flare-ups of the condition or assisting with the veteran's recovery. Provide your **best estimate** of how often (frequency) and how long (the duration) the intermittent episodes will likely last.

Over the next 6 months, intermittent care is estimated to occur ___________________ times per day week month and are likely to last approximately _____________ (hours / days) per episode.

Signature of Health Care Provider _________________________ Date _________ (mm/dd/yyyy)