



Printed Name of Employee: \_\_\_\_\_

(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    \_\_\_ Transportation

\_\_\_ Physical care    \_\_\_ Psychological comfort    \_\_\_ Other (please specify): \_\_\_\_\_

(7) **Give your best estimate of the amount of leave time 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 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).

**Employee Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

*Now provide this form to the veteran’s health care provider.*

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## Section II: Health Care Provider

Please provide your contact information, complete all relevant parts of this Section, and sign the form below. A family member of your patient has requested leave under the military caregiver leave provision of the FMLA to care for your patient as described in the preceding pages of this form. The FMLA allows an employer to require that the employee submit a timely, complete, and sufficient medical certification to support a request for FMLA military caregiver leave to care for a veteran with a serious health condition. For FMLA purposes, a “serious health condition” 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 Veteran’s Affairs Program of Comprehensive Assistance for Family Caregivers. For more information about the definitions of a serious health condition under the FMLA, see the chart at the end of the form.

“Need for care” includes both physical and psychological care. It includes situations where, for example, due to their

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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 health condition 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](#).

Provider's name: \_\_\_\_\_

Provider's business address: \_\_\_\_\_

Type of practice/Medical specialty: \_\_\_\_\_

Telephone: ( \_\_\_\_\_ ) \_\_\_\_\_ Fax: ( \_\_\_\_\_ ) \_\_\_\_\_

**Please attach a copy of your business card.**

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 CFR § 825.125

### **Part A: Medical Information**

Please provide appropriate medical information for the patient as requested below. Limit your responses to the veteran's condition for which the employee is seeking FMLA leave. Your answers should be your best estimate based upon your medical knowledge, experience, and examination of the patient. After completing Part A, complete Part B to provide information about the amount of leave needed. 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), genetic services, as defined in 29 C.F.R. § 1635.3(f), or genetic services, as defined in 29 CFR § 1635.3(e). If more room is needed to answer a question, please attach the rest of the answer.

(1) Patient's Name: \_\_\_\_\_

(2) State the approximate date the condition started or will start: \_\_\_\_\_ (mm/dd/yyyy)

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

(4) The veteran's illness or injury: *(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

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\_\_\_\_ 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 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 CFR § 825.113 of the FMLA. If such leave is requested, you may be required to complete a Certification Form seeking the same information.)*

## Part B: Amount of Leave Needed

For the medical condition(s) checked in Part A, complete all that apply. Several 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 military caregiver leave coverage.

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

(7) 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)*

(8) 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 (duration) the episodes of incapacity will likely last.

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

Signature of Health Care Provider \_\_\_\_\_ Date \_\_\_\_\_  
*(mm/dd/yyyy)*

**Do not send the completed form to the Department of Labor. Return form to the TU ADA/504 Coordinator.**