Family and Medical Leave Act
Certification for Serious Injury or Illness of Covered Servicemember - - for Military Family Leave

Form F

The Family and Medical Leave Act (FMLA) provides that eligible employees may take FMLA leave to care for a covered servicemember with a serious illness or injury. The FMLA allows an employer to require an employee seeking FMLA leave for this purpose to submit a medical certification. The employer must give the employee 15 calendar days to provide the certification from the date of application. If the employee fails to provide complete and sufficient certification, the FMLA leave request may be denied. **Completed forms should be sent via FCPS StaffConnect or via fax 571-423-5013.** More information about FMLA may be found on the FCPS website (www.fcps.edu, search "FMLA").

SECTION I: For Completion by the EMPLOYEE or EMPLOYER

While this form is not required, it asks the health care provider for the information necessary for a complete and sufficient medical certification. Please complete this section before giving this form to the servicemember or the servicemember's health care provider.

An employer requiring an employee to submit a certification for leave to care for a covered servicemember must accept as sufficient certification invitational travel orders (ITOs) or invitational travel authorizations (ITAs) issued to any family member to join an injured or ill servicemember at the servicemember's bedside. An ITO or ITA is sufficient certification for the duration of time specified in the ITO or ITA.

Employee's name: _____ Employee ID: _____

Employer name and contact: Fairfax County Public Schools, Financial Services Department, Benefits, 571-423-3200

SECTION II: For Completion by the EMPLOYEE and/or the CURRENT SERVICEMEMBER for whom the Employee Is Requesting Leave

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.

Part A: EMPLOYEE INOFORMATION

1. Name of current servicemember for whom the employee is requesting leave: _____

2. Select your relationship to the current servicemember:
   - ☐ 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 in 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.*

Employee Name: _____

Date Received by Disability and Leaves: _____

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PART B: SERVICEMEMBER INFORMATION AND CARE TO BE PROVIDED TO THE SERVICE MEMBER

3. The servicemember (☐ is/☐ is not) a current member of the Regular Armed Forces, the National Guard or Reserves. If yes, provide the servicemember's military branch, rank and unit currently assigned to:

   _____

4. The servicemember (☐ is/☐ is not) 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. If yes, provide the name of the medical treatment facility or unit: _____

5. The servicemember (☐ is/☐ is not) on the Temporary Disability Retired List (TDRL).

6. Briefly describe the care :
   - ☐ 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 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).*

Employers must generally maintain records and documents relating to medical certifications, recertifications, or medical histories of employees 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. The employer may not ask the employee to provide more information than allowed under the FMLA regulations, 29 C.F.R. §§ 825.306-825.308. Employees are not required to provide medical certification if requesting FMLA leave to bond with a healthy newborn child or a child placed for adoption or foster care. Legal Citations 29 U.S.C. §§ 2613, 2614(c)(3); 29 C.F.R. § 825.305;29 C.F.R. § 825.313 and C.F.R. § 825.600-604. 29 U.S.C. §§ 2613, 2614(c)(3); 29 C.F.R. § 825.305.

Employee Signature _____ **Date** _____ *(mm/dd/yyyy)*

SECTION III: For Completion by a UNITED STATES DEPARTMENT OF DEFENSE ("DOD") HEALTH CARE PROVIDER or a HEALTH CARE PROVIDER who is either: (1) a United States Department of Veterans Affairs ("VA") health care provider; (2) a DOD TRICARE network authorized private health care provider; or (3) a DOD non-network TRICARE authorized private health care provider

The employee listed in Section I 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 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.

PART A: HEALTH CARE PROVIDER INFORMATION

Health Care Provider's name and business address:

_____

SECTION III: (continued) Employee Name: _____

Type of practice or medical speciality: _____

Telephone: _____ Fax: _____ Email: _____

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. § 825.305.

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.

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 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 be service in the line of duty on active duty.
   - ☐ None of the above.
5. The servicemember (☐ is/ ☐ is not) undergoing medical treatment, recuperation, or therapy for this condition.
   If yes, briefly describe the medical treatment, recuperation or therapy: _____
   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(e), or the manifestation of disease or disorder in the employee's family members, 29 C.F.R. § 1635.3(b).
6. The current servicemember's medical condition is classified as: *(Select as possible)*

   - ☐ **(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 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.*

Employee Name: _____

PART C: AMOUNT OF LEAVE NEEDED

For the medical condition(s) checked in Part B, complete all that apply. Smequestions 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 servicemember will need care for a continuous period of time, including any time for treatment(s) and/or 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 servicemember to attend planned medical treatment(s) (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 employee to be absent from work to provide care for the patient on an intermittent basis (periodically), such as the care needed because of episodic flare-ups of the condition or assisting with the servicemember's recovery Provide your best estimate of how often (frequency) and how long (duration) the intermittent episodes will likely last.

   Over the next 6 months, episodes of incapacity are estimated to occur _____ times per (☐ day / ☐ week / ☐ month) and are likely to last approximately _____ (☐ hours / ☐ days) per episode.

PART D: SIGNATURE

_____ _____

Signature of Health Care Provider **Date**