NEW YORK CITY HEALTH + HOSPITALS
Certification for Serious Injury or Illness
of Covered Service Member/Veteran for Military Family Leave
Family and Medical Leave Act (FMLA)

Employee's Name: _____Employee's Title: _____

Hospital or Central Office:_____ Work Location:_____

Regular work schedule: _____

The Family and Medical Leave Act (FMLA) provides that an employee seeking FMLA leave due to the serious Injury or illness of a covered service member/veteran submit a certification to his employer providing sufficient Facts to support the request for leave.

SECTION I: For Completion by the EMPLOYEE and/or the COVERED SERVICE MEMBER/VETERAN for whom the Employee Is Requesting Leave
INSTRUCTIONS to the EMPLOYEE or COVERED SERVICE MEMBER/VETERAN: Please complete Section I before having Section II completed. Please have your medical provider complete the attached medical certification to support your request for FMLA leave due to a serious injury or illness of a covered service member/veteran - (applies to veterans who were members of the Armed Forces within the preceding five years.) Return this form within 15 calendar days of its receipt.

SECTION II: 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
INSTRUCTIONS to the HEALTH CARE PROVIDER: The employee listed on Page 2 has requested leave under the FMLA to care for a family member who is a veteran/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. For purposes of FMLA leave, a serious injury or illness is one that was incurred in the line of duty on active duty, or the aggravation of an existing or pre-existing injury or illness that was aggravated while on active duty that may render the service member medically unfit to perform the duties of his or her office, grade, rank, or rating. A complete and sufficient certification to support a request for FMLA leave due to a covered service member/veteran's serious injury or illness includes written documentation confirming that the covered service member/veteran's injury or illness was incurred in the line of duty on active duty and that the covered service member is undergoing

treatment for such injury or illness by a health care provider listed above. Answer, fully and completely, all applicable parts. 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 coverage. Limit your responses to the condition for which the employee is seeking leave.

SECTION I: For Completion by the EMPLOYEE and/or the COVERED SERVICE MEMBER/VETERAN for whom the Employee Is Requesting Leave: (This section must be completed first before any of the below sections can be completed by a health care provider.)

PART A: EMPLOYEE INFORMATION

Please provide the name of the medical treatment facility or unit where covered service member/veteran is being treated.

_____
_____
_____

Name and Address of Employer (this is the employer of the employee requesting leave to care for covered service member/veteran):

_____
_____
_____

Name of Employee Requesting Leave to Care for Covered Service Member/Veteran

_____
First Middle Last

Name of Covered Service Member/Veteran (for whom employee is requesting leave to care):

_____
First Middle Last

Relationship of Employee to Covered Service Member/Veteran Requesting Leave to Care:
Spouse_____ Parent_____ Son_____ Daughter_____ Next of Kin _____

PART B: COVERED SERVICE MEMBER/VETERAN INFORMATION

(1) Is/Was the Covered Service Member/Veteran a Member of the Regular Armed Forces, the National Guard or Reserves? _____ Yes _____ No

If yes, please provide the covered service member's military branch, rank, and unit currently assigned to: _____

Is the covered service member/veteran 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)?

_____Yes _____No

(2) Is the Covered Service Member/Veteran on the Temporary Disability Retired List (TDRL)?

_____Yes _____No

PART C: CARE TO BE PROVIDED TO THE COVERED SERVICE MEMBER/VETERAN

Describe the care to be provided to the Covered Service Member/Veteran and an estimate of the leave needed to provide the care:

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

SECTION II: 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. If you are unable to make certain of the military-related determinations contained below in Part B, you are permitted to rely upon determinations from an authorized DOD representative (such as a DOD recovery care coordinator). (Please ensure that Section I above has been completed before completing this section.) **Please be sure to sign the form on the last page.**

PART A: HEALTH CARE PROVIDER INFORMATION

Health Care Provider's Name and Business Address:

_____
_____

Type of Practice/Medical Specialty: _____

Please state whether you are either: (1) a DOD health care provider; (2) a VA health care provider; (3) a DOD TRICARE network authorized private health care provider; or (4) a DOD non-network TRICARE authorized private health care provider:

Telephone: ( ) _____Fax: ( ) _____ Email: _____

PART B: MEDICAL STATUS

(1) Covered Service Member/Veteran's medical condition is classified as (Check One of the Appropriate Boxes):

☐ **(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 service member 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 § 825.113 of the FMLA. If such leave is requested, you may be required to complete an employer-provided form seeking the same information.)

(2) Was the condition for which the Covered Service Member/Veteran is being treated incurred in line of active duty while serving in the armed forces? ___Yes ___No

(3) Approximate date condition commenced: _____

(4) Probable duration of condition and/or need for care: _____

(5) Is the covered service member/veteran undergoing medical treatment, recuperation, or therapy? ____ Yes ____ No

If yes, please describe medical treatment, recuperation or therapy:

_____
_____
_____
_____
_____

PART C: COVERED SERVICE MEMBER/VETERAN'S NEED FOR CARE BY FAMILY MEMBER

(1) Will the covered service member/veteran need care for a single continuous period of time, including any time for treatment and recovery? ___ Yes ___ No

If yes, estimate the beginning and ending dates for this period of time: _____

(2) Will the covered service member/veteran require periodic follow-up treatment appointments? ___Yes ___ No

If yes, estimate the treatment schedule: _____

(3) Is there a medical necessity for the covered service member/veteran to have periodic care for these follow-up treatment appointments? ___ Yes ___ No

(4) Is there a medical necessity for the covered service member/veteran to have periodic care for other than scheduled follow-up treatment appointments (e.g., episodic flare-ups of medical condition)? ____Yes ____No

If yes, please estimate the frequency and duration of the periodic care:

_____
_____
_____
_____

Signature of Health Care Provider: _____Date: _____