Certification for Serious Injury or Illness of a Current Service Member for Military Family Leave

The Family and Medical Leave Act (FMLA) provides that eligible employees make take FMLA leave to care for a covered veteran with a serious illness or injury. The FMLA allows The City of Salem to require an employee seeking FMLA leave for this purpose to submit a medical certification. 29 U.S.C. §§ 2613, 2614(c)(3). The employer must give the employee **at least 15 calendar days** to provide the certification. If the employee fails to provide complete and sufficient certification, their FMLA leave request may be denied. 29 C.F.R § 825.313.

Section 1: Either the employee or The City of Salem may complete.

This form asks the health care provider for the information necessary for a complete and sufficient medical certification. **The City of Salem may not ask an employee to provide more information than allowed under the FMLA regulations, 29 C.F.R. § 825.310. Recertifications are not allowed for FMLA leave to care for a covered servicemember. Where medical certification is requested by The City of Salem, 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.** The City of Salem must accept as sufficient certification invitational travel orders (ITOs) or invitational travel authorizations (ITAs) issued to an y family member to join an injure 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.

The City of Salem 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 purposed 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.

Part A: General Information

Employer Information:

City of Salem, Human Resources Division

295 Church St. SE Suite 210 Phone: 503-588-6162

Salem, OR 97301 Fax: 503-588-6170

Employee Full Name:

Date:

Due Date: (add 15 calendar day to date)

Section 2: Employee and/or Current Servicemember to complete.

Please fully complete section 2 before having the veteran's health care providers Section 3. The FMLA allows an The City of Salem 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 City of Salem, the employee is required to obtain or retain the benefit of FMLA-protected leave.

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Part A: Employee Information

Full name of current servicemember for whom employee is requesting leave:

Select employee's relationship to the veteran: Next of Kin

Part B: Servicemember information and care to be provided to the Servicemember

The servicemember (☐ is / ☐ is not) a current member of the Regular Armed Forces, the National Guard or Reserves.

If "is", provide the servicemember's military branch, rank, and unit currently assigned to:

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 "is", provide the name of the medical treatment facility or unit:

Type(s) of care the employee will provide to the servicemember: *Check all that apply.*

- ☐ Assistance with basic medical, hygienic, nutritional, or safety needs
- ☐ Transportation
- ☐ Psychological Comfort
- ☐ Physical Care
- ☐ Other:

Please give your **best estimate** of the amount of FMLA leave needed to provide the care described:

If a reduced work schedule is necessary to provide the care described, give your best estimate of the reduced work schedule the employee will be able to work.

From to

For hours per day at days per week.

Section 3: Health Care Provider to complete.

Please complete all parts of this section fully, then sign the form. The employee named in Section 1 has requested leave under the military caregiver leave provision of the FMLA to care for a family member that 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 the 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 (VASD) of 50 percent or greater, and such VASRD rating is based, in whole or in part, on the condition participating 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 need transportation to the doctor. It also included 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.

Part A: Health Care Provider Information

Provider's Full Name:

Provider's business address:

Type of Practice/ Medical Specialty:

Contact Information:

Phone:

Fax:

E-mail:

Please select the type(s) of FMLA health care provider:

- ☐ 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 responses to the veteran's condition for which the employee is seeking leave. If unable to make certain military-related determinations contained below, providers are permitted to rely upon determination from an authorized DOD representative, such as a DOD Recovery Care Coordinator, or an authorized VA representative. Do not provide

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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).

Patient's Full Name:

Provide the approximate date the condition stated or will start:

Provide the **best estimate** of how long the condition will last:

The servicemember's injury or illness:

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

If "is", please describe the medical treatment, recuperation, or therapy:

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

☐ (VSI) Very Seriously Ill/Injured: Illness/ Injury is of such a severity that life is imminently endangered. Family members are requested at beside. *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 beside. *Please note this is an internal DOD casualty assistance designation used by DOD healthcare providers.*

☐ Other Ill/Injury: 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.

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. Answers should be **best estimates** based on medical knowledge, experience, and examination of the patient. Be as specific as possible; terms such as "lifetime," "unknown," or "indeterminate" may not be sufficient to determine FMLA military caregiver leave coverage.

Due to the condition, the servicemember will need care for a **continuous period of time**, including any time for treatment and recovery.

Please provide the **best estimate** of the beginning date and end date for this period of time.

Due to the condition, it is medically necessary for the servicemember to attend planned medical treatment appointments (schedules medical visits).

Please provide the **best estimate** of the duration of the treatment(s), including any period(s) of recovery: *(e.g. 3days/week)*

Due to the condition, it is medically necessary for the servicemember 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.

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Please provide the **best estimate** of how often (frequency) and how long (duration) the episodes of incapacity will likely last.

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

Signature of Health Care Provider _____