



## CERTIFICATION FOR SERIOUS INJURY OR ILLNESS OF A VETERAN FOR MILITARY CAREGIVER 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. **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.** In lieu of this form, The City of Salem **must** accept as sufficient certification of the veteran’s serious injury or illness documentation indicating the veteran’s enrollment in the Department of Affairs Program of Comprehensive Assistance for Family Caregivers. **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.**

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  
Salem, OR 97301

Phone: 503-588-6162  
Fax: 503-588-6170

#### Employee Full Name:

Date:

Due Date: (add 15 calendar day to date)

### Section 2: Employee and/or Veteran 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. The City of Salem must give an employee at least 15 calendar days to return this form to The City of Salem. 29 U.S.C §§ 2613, 2614(c)(3).



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### Part A: Employee Information

Full name of veteran for whom employee is requesting leave:

Select employee's relationship to the veteran:

### Part B: Veteran Information and Care to be Provided to the Veteran

The veteran was ( honorably /  dishonorably) discharged or release from the Armed Forces, including the National Guard or Reserves.

Date of veteran's discharge:

Veteran's military branch, rank, and unit at time of discharge:

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

Type(s) of care the employee will provide to the veteran: *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

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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

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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), or genetic services, as defined in 29 C.F.R. § 1635.3(e).

Patient's Full Name:

Provide the approximate date the condition started or will start:

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

The veteran's injury or illness:

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

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

The veteran's medical condition 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 no 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)
- 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.

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



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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 \_\_\_\_\_

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