MEDICAL CERTIFICATION – SERIOUS INJURY OR ILLNESS OF COVERED SERVICE MEMBER FOR MILITARY FAMILY LEAVE (FMLA)

SECTION I: For Completion by the EMPLOYEE and/or the COVERED SERVICE MEMBER for whom the Employee is Requesting Leave

Instructions to the EMPLOYEE or COVERED SERVICE MEMBER: 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 (29 U.S.C. §§ 2613, 2614 (c) (3)). Failure to do so may result in a denial of an employee's FMLA request (29 C.F.R. § 825.310 (f)) The employer must give an employee at least 15 calendar days to return this form to the employer.

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:

PLEASE NOTE: THE HEALTH CARE PROVIDER IS NOT TO DISCLOSE THE UNDERLYING DIAGNOSIS WITHOUT THE CONSENT OF THE PATIENT.

The employee listed on Page 2 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. For purposes of FMLA leave, a serious injury or illness is one that was incurred in the line of active duty that may render the servicemember 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 servicemember's serious injury or illness includes written documentation confirming that the covered servicemember's injury or illness was incurred in the line of duty on active duty and that the covered servicemember 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 SERVICEMEMBER for whom the Employee is Requesting Leave: (This section must by completed first before any of the below sections can be completed by a health care provider.)

PART A: EMPLOYEE INFORMATION

Name and address of Employer (this is the employer of the employee requesting leave to care for covered servicemember):

Employer: County of Santa Barbara Department: _____

Department Address: _____

Street City State Zip

Departmental Contact: _____ Phone: _____

_____

Name of Employee Requesting Leave to Care for Covered Servicemember:

_____

First Middle Last

Name of Covered Servicemember (for whom employee is requesting leave to care for):

_____

First Middle Last

☐ SPOUSE ☐ PARENT ☐ SON ☐ DAUGHTER ☐ NEXT OF KIN

PART B: COVERED SERVICEMEMBER INFORMATION

1. Is the Covered Servicemember a current Member of the Regular Armed Forces, the National Guard or Reserves?

   ☐ Yes ☐ No

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

   _____

   Is the covered servicemember assigned to a military treatment facility as an outpatient or to a unit established for the purpose of providing command control of members of the Armed Forces receiving medical care as outpatients (such as a medical hold or warrior transition unit)?

   ☐ Yes ☐ No If yes, please provide the name of the medical treatment facility or unit:

   _____

2. Is the Covered Servicemember on the Temporary Disability Retired List (TDRL)?

   ☐ Yes ☐ No

PART C: CARE TO BE PROVIDED TO THE COVERED SERVICEMEMBER
Describe the Care to Be Provided to the Covered Servicemember 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 INFORMATIOIN
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 Servicemember'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 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 § 825.113 of the FMLA. If such leave is requested, you may be required to complete the County of Santa Barbara form titled **"Medical Certification – Employee's Family Members' Serious Health Condition (FMLA/CFRA)"** seeking the same information).

2. Was the condition for which the Covered Servicemember is being treated incurred in the line of duty on active duty 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 servicemember undergoing medical treatment, recuperation, or therapy?

☐ Yes ☐ No If yes, please describe medical treatment, recuperation or therapy:

_____

_____

PART C: COVERED SERVICEMEMBER'S NEED FOR CARE BY FAMILY MEMBER

1. Will the covered servicemember need care for a single continuous period of time, including any time for treatment and recovery? ☐ Yes ☐ No

2. Will the covered servicemember require periodic follow-up treatment appointments?

☐ Yes ☐ No If yes, estimate the treatment schedule:

_____

_____

3. Is there a medical necessity for the covered servicemember to have periodic care for these follow-up treatment appointments? ☐ Yes ☐ No

4. Is there a medical necessity for the covered servicemember 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: _____

Print Name: _____

Date: _____