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COUNTY OF RIVERSIDE
Human Resources Department

CERTIFICATION FOR SERIOUS INJURY OR ILLNESS OF COVERED SERVICEMEMBER -- FOR MILITARY CAREGIVER LEAVE

♦ **Family and Medical Leave Act (FMLA)**

SECTION I: For Completion by the EMPLOYEE

Employee Name (Last, First, Middle):

Daytime Contact Phone Number:
( )

Department

Employee ID Number:

Name (Last, First, Middle) of covered servicemember (for whom employee is requesting caregiver leave):

Your relationship to the covered servicemember::

◯ **Child** ◯ **Spouse** ◯ **Parent** ◯ **Next of Kin (as defined by FMLA regulations)**

PART A. 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 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

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

(3) Is the covered servicemember a Veteran of the Regular Armed Forces, the National Guard or Reserves?

☐ Yes ☐ No

If yes, please provide date of discharge:

PART B. CARE TO BE PROVIDED TO THE COVERED SERVICEMEMBER

Describe the care to be provided to the covered servicemember:

Estimate the amount of leave needed to provide care:

SECTION II. For Completion by the HEALTH CARE PROVIDER

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 Veteran Affairs ("VA") health care provider; (2) a DOD TRICARE network authorized private health care provider; (3) a DOD non-network TRICARE authorized private health care provider; or (4) a health care provider as defined by §825.125. If you are unable to make certain of the military-related determination contained 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 has been completed before completing this section. Please be sure to sign and date the form on the last page.**

The Genetic Information Nondiscrimination Act of 2008 (GINA) prohibits employers and other entities governed by GINA Title II from requesting or requiring genetic information of an individual or family member of the individual, except as specifically allowed by this law. To comply with this law, we are asking that you not provide any genetic information when responding to this request for medical information. "Genetic Information," as defined by GINA, includes an individual's family medical history, the results of an individual's or family member's genetic tests, the fact that an individual or individual's family member sought or received genetic services, and genetic information of a fetus to be carried by an individual or an individual's family member or an embryo lawfully held by an individual or family member receiving assistive reproductive services.

Employee Name (Last, First, Middle):	Employee ID Number:

PART A. HEALTH CARE PROVIDER INFORMATION

Please indicate whether you are a:

- ☐ 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
- ☐ Other health care provider as defined by §825.125

Health Care Provider's Name and Business Address (you may attach a business card in lieu of completing this section):

Type of Practice/Medical Speciality | License Number:

Telephone: ( ) | Fax: ( ) | Email:

PART B. MEDICAL STATUS FOR CURRENT SERVICE MEMBERS (If covered service member is a veteran, proceed to Parts C & D.)

(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 are requested at bedside immediately. (Please note this is an internal DOD casualty assistance designation used by DOD health care 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 health care 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 the 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 a leave is requested, you may be required to complete the applicable request form.)

(2) Was the condition for which the covered servicemember is being treated incurred in 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 the medical treatment, recuperation, or therapy:

_____

_____

PART C. MEDICAL STATUS FOR MILITARY VETERANS

The covered veteran's medical condition is classified as **(check all that apply)**:

☐ 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.

☐ A physical or mental condition for which the covered veteran has received a U.S. Department of Veterans Affairs Related Disability Rating (VASRD) of 50 percent or higher and such VASRD rating is based, in whole or in part, on the condition precipitating the need for military caregiver leave.

☐ 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 services, or would do so absent treatment.

Employee Name (Last, First, Middle):	Employee ID Number:

☐ 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.

☐ None of the above (Note to the 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 a leave is requested, you may be required to complete the applicable request form.)

PART D. 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

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

_____

(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

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

_____

(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 **Date**