STATE OF WEST VIRGINIA

FEDERAL FAMILY and MEDICAL LEAVE ACT (FMLA)

Certification for Serious Injury or Illness of a Current Servicemember – for Military Family Leave

NOTICE TO THE EMPLOYER

INSTRUCTIONS to the EMPLOYER: The Family and Medical Leave Act (FMLA) provides that an employer may require an employee seeking FMLA leave due to a serious injury or illness of a current servicemember to submit a certification providing sufficient facts to support the request for leave. Employers must generally maintain records and documents relating to medical certifications, recertifications, or medical histories of employees or employees' family members created for FMLA purposes as confidential medical records in separate files/records from the usual personnel files and in accordance with § 29 CFR 1630.14(c)(1) of the Americans with Disabilities Act applies.

SECTION I: For Completion by the EMPLOYEE and/or the CURRENT SERVICEMEMBER for whom the Employee Is Requesting Leave.

INSTRUCTIONS to the EMPLOYEE or CURRENT SERVICEMEMBER: 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 current 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 CFR 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 a United States Department of Veterans Affairs (VA) health care provider, a DOD TRICARE network authorized private health care provider, a DOD non-network TRICARE authorized private health care provider, or a health care provider as defined in § 29 CFR 825.125.

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 current 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 in the Armed Forces or that existed before the beginning of the member's active duty and was aggravated by service in the line of duty on active duty in the Armed Forces 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 current servicemember's serious injury or illness includes written documentation confirming that the servicemember's injury or illness was incurred in the line of duty on active duty or if not, that the current servicemember's injury or illness existed before the beginning of the servicemember's active duty and was aggravated by service in the line of duty on active duty in the Armed Forces, and that the current 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 servicemember's condition for which the employee is seeking leave.

The Genetic Information Nondiscrimination Act of 2008 (GINA) prohibits employers and other entities covered 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 an individual's family member sought or received genetic services, and genetic information of a fetus 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. Family medical history is required only to the extent necessary to make the medical certification complete and sufficient under FMLA.

SECTION I: For Completion by the EMPLOYEE and/or the CURRENT SERVICEMEMBER 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

Name and address for the employer of the person requesting leave to care for the current servicemember:

EMPLOYER NAME:

EMPLOYER ADDRESS:

Name of employee requesting leave to care for the current servicemember:

EMPLOYEE NAME (First, Middle/Middle Init., and Last):

Name of the current servicemember for whom employee is requesting leave to care:

SERVICEMEMBER NAME (First, Middle/Middle Init., and Last):

Employee relationship to current servicemember: ☐ Spouse ☐ Parent ☐ Son/Daughter ☐ Next of Kin

If Next of Kin, specify relationship:

PART B: SERVICEMEMBER INFORMATION

☐Yes ☐ No Is the servicemember a current member of the Regular Armed Forces, the National Guard, or Reserves? If yes, provide the servicemember's military branch, rank, and currently assigned unit below:

BRANCH: RANK:

ASSIGNED UNIT:

☐Yes ☐ No Is the 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)? **If yes, provide the name of the medical treatment facility or unit below:**

FACILITY:

☐Yes ☐ No Is the servicemember on the Temporary Disability Retired List (TDRL)?

Part C: CARE TO BE PROVIDED TO THE SERVICEMEMBER

Describe the care to be provided to the current servicemember and an estimate of the leave that will be needed to provide the care:

SECTION II: Please ensure that Section I above has been completed before completing this section. Be sure to sign the form on the last page.

For Completion by a United States Department of Defense (DOD) Health Care Provider or a Health Care Provider who is either a United States Department of Veterans Affairs (VA) health care provider, a DOD TRICARE network authorized private health care provider, a DOD non-network TRICARE authorized private health care provider, or a health care provider as defined in § 29 CFR 825.125. 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).

PART A: HEALTH CARE PROVIDER INFORMATION

Health Care Provider's name, address, phone, fax, email, and type of practice/specialty:

PROVIDER NAME:

PROVIDER ADDRESS:

PROVIDER PRACTICE/SPECIALTY:

PHONE and FAX NUMBERS: PH: FAX:

EMAIL ADDRESS:

Please check the appropriate box below whether you are either:

☐ 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 CFR 825.125

PART B: MEDICAL STATUS

The current 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) Other Illness/Injury – A serious illness or injury 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 a U.S. Department of Labor FORM WH-380-F or an employer-provided form seeking the same information.)

☐Yes ☐ No Is the servicemember being treated for a condition which was incurred or aggravated by service in the line of duty on active duty in the Armed Forced?

Approximate date condition commenced:

Probable duration of condition and/or need for care:

☐Yes ☐ No Is the servicemember undergoing medical treatment, recuperation, or therapy for this condition?

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

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

☐Yes ☐ No Will the servicemember need care for a single continuous period of time, including any time for treatment and recovery? **If yes, estimate the beginning and ending dates for this period of time below:**

BEG. DATE: END. DATE:

☐Yes ☐ No Will the servicemember require periodic follow-up treatment appointments? **If yes, estimate the treatment schedule below:**

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

☐Yes ☐ No Is there a medical necessity for the servicemember to have periodic care for other than scheduled follow-up treatment appointments (e.g., episodic flare-ups of medical condition)? **If yes, please estimate the frequency and duration of the periodic care below:**

NOTE TO HEALTH CARE PROVIDER: Return the form to the patient; **DO NOT** send the completed form to the employer.

HEALTH CARE PROVIDER SIGNATURE _____ DATE SIGNED: _____