STATE OF WEST VIRGINIA

FEDERAL FAMILY and MEDICAL LEAVE ACT (FMLA)

Certification for Serious Injury or Illness of a Veteran – 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 military caregiver leave under the FMLA leave due to a serious injury or illness of a covered veteran 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), if the Americans with Disabilities Act applies.

SECTION I: For Completion by the EMPLOYEE and/or the VETERAN for whom the Employee is Requesting Leave.

INSTRUCTIONS to the EMPLOYEE and/or VETERAN: 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 military caregiver leave under the FMLA leave due to a serious injury or illness of a covered veteran. 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: (1) a United States Department of Defense ("DOD") health care provider; (2) a United States Department of Veterans Affairs ("VA") health care provider; (3) a DOD TRICARE network authorized private health care provider; (4) a DOD non-network TRICARE authorized private health care provider; or (5) a health care provider as defined in § 29 CFR 825.125.

INSTRUCTIONS to the HEALTH CARE PROVIDER: The employee named in Section I has requested leave under the military caregiver leave provision of the FMLA to care for a family member who is a veteran. 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 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 (VASRD) of 50 percent or greater, and such VASRD rating is based, in whole or in part, on the condition precipitating 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.

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 below. 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 military caregiver leave coverage. Limit your responses to the veteran'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 VETERAN 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 veteran:

EMPLOYER NAME:

EMPLOYER ADDRESS:

Name of employee requesting leave to care for the veteran:

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

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

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

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

If Next of Kin, specify relationship:

PART B: VETERAN INFORMATION

Date of veteran's discharge:

☐Yes ☐ No Was the veteran dishonorably discharged or released from the Armed Forces (including the National Guard or Reserves)?

Provide the veteran's military branch, rank, and unit at the time of discharge:

BRANCH: RANK:

ASSIGNED UNIT:

☐Yes ☐ No Is the veteran receiving medical treatment, recuperation, or therapy for an injury or illness?

Part C: CARE TO BE PROVIDED TO THE VETERAN

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

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

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

If you are unable to make certain of the military-related determinations contained in Part B, you are permitted to rely upon determinations from an authorized DOD representative (such as, DOD Recovery Care Coordinator) or an authorized VA representative. See Section 1, Part A above.

The veteran's medical condition is classified as (check one of the appropriate boxes):

☐ 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 Service Related Disability Rating (VASRD) of 50% 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 service, or would do so absent treatment.

☐ 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.

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

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

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

"Need for care" encompasses both physical and psychological care. It includes situations where, for example, due to his or her serious injury or illness, the veteran is unable to care for his or her own basic medical, hygienic, or nutritional needs or safety, or is unable to transport him- or herself to the doctor. It also includes providing psychological comfort and reassurance which would be beneficial to the veteran who is receiving inpatient or home care.

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

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

☐Yes ☐ No Is there a medical necessity for the veteran 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: _____