Date Issued: _____

CITY OF ST. LOUIS
CERTIFICATION FOR SERIOUS INJURY OR ILLNESS OF COVERED SERVICEMEMBER—FOR MILITARY FAMILY LEAVE (FAMILY AND MEDICAL LEAVE ACT)

SECTION I: For completion by the EMPLOYEE and/or the COVERED SERVICE MEMBER 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 of employer (this is the employer of the employee requesting leave to care for covered servicemember): _____
_____
_____

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):

_____
First Middle Last

Relationship of employee to covered servicemember requesting leave to care:
____ 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 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 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 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 INFORMATION

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:

_____

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 DOL FORM WH-380 or an employer-provided form seeking the same information.)

(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 medical treatment, recuperation, or therapy: _____
_____
_____

PART C: 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 ____.

(4) Is there a medical necessity for the covered servicemember to have periodic care other than for 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

Printed Name of Health Care Provider: _____

Type of Practice: _____

Phone Number: _____Fax Number: _____