Certification for Serious Injury or Illness of a Veteran for Military Caregiver Leave
(Family and Medical Leave Act)
U.S. Department of Labor
Wage and Hour Division

RETURN TO THE PATIENT - DO NOT SEND COMPLETED FORM TO THE DEPARTMENT OF LABOR.

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The Family and Medical Leave Act (FMLA) provides that eligible employees may take FMLA leave to care for a covered veteran with a serious illness or injury. The FMLA permits an employer to require an employee seeking FMLA leave for this purpose to submit a medical certification. 29 U.S.C. §§ 2613, 2614(c)(3). The employer must give the employee **at least 15 calendar days**, absent unusual circumstances, to provide the certification. If the employee is unable to provide complete and sufficient certification, his or her FMLA leave request may be denied. 29 C.F.R. § 825.313. Information about the FMLA may be found on the WHD website at http://www.dol.gov/whd/fmla.

SECTION I – EMPLOYER

Please complete this section before giving the form to your employee.

(1) Employee name: _____
First *Middle* *Last*

(2) Employer Name: _____ Date: _____
(List date certification requested from employee)

(3) On _____ *(date)*, we learned of your need for leave beginning on _____ *(date)* to care for a veteran with an illness or injury.

(4) This certification must be returned no later than: _____
*(List date certification is due, which must be at least **15 calendar days** from the date the certification is given to the employee)*

SECTION I - EMPLOYER INSTRUCTIONS

Please complete Section I before giving this form to your employee. Your response is voluntary. While you are not required to use this form, **you may not ask the employee to provide more information than allowed under the FMLA regulations, 29 C.F.R. § 825.310**. Information about the FMLA may be found on the WHD website at http://www.dol.gov/whd/fmla.

In lieu of this form or your own certification form, you must accept as sufficient certification of the veteran's serious injury or illness documentation indicating the veteran's enrollment in the Department of Veterans Affairs Program of Comprehensive Assistance for Family Caregivers.

Where medical certification is requested by an employer, an employee may not be held liable for administrative delays in the issuance of military documents, despite the employee's diligent, good-faith efforts to obtain such documents. Employers must generally maintain records and documents relating to medical information, 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 C.F.R. § 1630.14(c)(1), if the Americans with Disabilities Act applies, and in accordance with 29 C.F.R. § 1635.9, if the Genetic Information Nondiscrimination Act applies.

Employee Name: _____

SECTION II - EMPLOYEE and/or VETERAN

The FMLA allows 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 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. The employer must give an employee **at least 15 calendar days** to return this form to the employer.
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). Information about the FMLA may be found at on the WHD website at http://www.dol.gov/whd/fmla.

Please complete all Parts in Section II before having the health care provider complete Section III.

PART A: EMPLOYEE INFORMATION

(1) Name of veteran for whom employee is requesting leave: _____
First *Middle* *Last*

(2) Relationship of employee to the veteran:
(Select as appropriate)

- ☐ Spouse
- ☐ Parent, including *in loco parentis*
- ☐ Son or daughter of any age, including *in loco parentis*
- ☐ Next of Kin

("Next of kin" is the veteran's nearest blood relative, other than the spouse, parent, son, or daughter, in the following order of priority: (1) a blood relative as designated in writing by the veteran for purposes of FMLA leave, (2) blood relatives granted legal custody of the veteran, (3) brothers and sisters, (4) grandparents, (5) aunts and uncles, and (6) first cousins. An employee may take FMLA leave to care for an individual who assumed the obligations of a parent to the employee when the employee was a child. An employee may also take FMLA leave to care for a child for whom the employee has assumed the obligations of a parent.)

(*In loco parentis* refers to a relationship in which a person assumes the obligations of a parent to a child. This means that an employee may take FMLA leave to care for a covered servicemember who assumed the obligations of a parent to the employee when the employee was a child. An employee may also take FMLA leave to care for a covered servicemember for whom the employee has assumed the obligations of a parent.)

PART B: VETERAN INFORMATION

(1) Date of the veteran's discharge: _____

(2) Please provide the veteran's military branch, rank and unit at the time of discharge: _____

_____

(3) Check if applicable:

- ☐ The veteran was dishonorably discharged or released from the Armed Forces, including the National Guard or Reserves.

(4) The veteran:

- ☐ is receiving medical treatment, recuperation, or therapy for an injury or illness
- ☐ is not receiving medical treatment, recuperation, or therapy for an injury or illness

Employee Name: _____

PART C: CARE TO BE PROVIDED TO THE VETERAN

(1) Briefly describe the care you will provide to your family member:
(Select as appropriate)

- ☐ Assistance with basic medical, hygienic, nutritional, or safety needs
- ☐ Transportation
- ☐ Physical Care
- ☐ Psychological Comfort
- ☐ Other: _____

(2) Give your **best estimate** of the amount of FMLA leave needed to provide the care described: _____

_____

(3) If a reduced work schedule is necessary to provide the care described, give your **best estimate** of the reduced work schedule needed:

Starting date _____ Ending date _____

Hour(s) per day _____ Day(s) per week _____

SECTION III - HEALTH CARE PROVIDER

Please provide your contact information, complete all Parts of this Section fully and completely, and sign the form below. See page 5 for further instructions.

PART A: HEALTH CARE PROVIDER INFORMATION

Health Care Provider's Name: *(Print)* _____

Health Care Provider's business address: _____

Type of Practice/Medical Specialty: _____

Please select the type of FMLA health care provider you are:

- ☐ 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, or
- ☐ Health care provider as defined in 29 CFR 825.125.

Telephone: ( ) _____ Fax: ( ) _____

E-mail address: _____

Employee Name: _____

PART B: MEDICAL INFORMATION

If you are unable to make certain military-related determinations contained below, you are permitted to rely upon determinations from an authorized DOD representative, such as a DOD Recovery Care Coordinator, or an authorized VA representative.

(1) Patient's Name: _____

(2) List the approximate date condition started or will start: _____

(3) Provide your **best estimate** of how long the condition will last: _____

Limit your responses to the veteran's condition for which the employee is seeking leave. Do not provide information about genetic tests, as defined in 29 C.F.R. § 1635.3(f), or genetic services, as defined in 29 C.F.R. § 1635.3(e). 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.

(4) The veteran's injury or illness: *(check one of the appropriate boxes)*

- ☐ Was incurred in the line of duty on active duty
- ☐ Existed before the beginning of the veteran's active duty and was aggravated by service in the line of duty on active duty

(5) The veteran: *(check one of the appropriate boxes)*

- ☐ Is not undergoing medical treatment, recuperation, or therapy for this condition
- ☐ Is undergoing medical treatment, recuperation, or therapy for this condition. Briefly describe the medical treatment, recuperation, or therapy: _____
  _____

(6) The veteran's medical condition is:

(Select as appropriate)

- ☐ 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 not able 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. *(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 29 C.F.R. § 825.113 of the FMLA. If such leave is requested, you may be required to complete DOL FORM WH-380-F or an employer-provided form seeking the same information.)*

Employee Name: _____

Part C: Amount of Leave Needed

Please provide information concerning the amount of leave the employee will be needed to provide care for the veteran.

(Select as appropriate)

☐ (1) Due to the condition, the veteran will need care for a **continuous period of time**, including any time for treatment and recovery. Provide your **best estimate** of the beginning and ending dates for this period of time:

_____

_____

☐ (2) Due to the condition, it is medically necessary for the veteran to attend **planned medical treatment** appointments. Provide your **best estimate** of the treatment schedule, if any, including the date(s) of any scheduled appointment(s) and the time required for each appointment:

_____

_____

☐ (3) Due to the condition, it is medically necessity for the veteran to receive care on an **intermittent basis** (periodically), such as the care needed because of episodic flare-ups of the condition or assisting with the veteran's recovery.

Provide your **best estimate** of how long (the duration) and how often (the frequency) the intermittent episode(s) will last *(e.g. 2 hours each episode, 1 time per week)*:

Amount of Time (Duration)	**How Often (Frequency)**
_____ Hour(s)	_____ per Day
_____ Day(s)	_____ per week
_____ Week(s)	_____ per Month
_____ Month(s)	_____ per Year

Signature of Health Care Provider_____ **Date** _____

Employee Name: _____

SECTION III - HEALTH CARE PROVIDER INSTRUCTIONS

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:

(1) 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
(2) 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
(3) 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
(4) 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.

"Need for care" includes both physical and psychological care. It includes situations where, for example, due to his or her serious injury or illness, the veteran is not able 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.

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 above. Information about the FMLA may be found on the WHD website at http://www.dol.gov/whd/fmla.

PAPERWORK REDUCTION ACT NOTICE AND PUBLIC BURDEN STATEMENT

If submitted, it is mandatory for employers to retain a copy of this disclosure in their records for three years, in accordance with 29 U.S.C. § 2616; 29 C.F.R. § 825.500. Persons are not required to respond to this collection of information unless it displays a currently valid OMB control number. The Department of Labor estimates that it will take an average of 15 minutes for respondents to complete this collection of information, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. If you have any comments regarding this burden estimate or any other aspect of this collection information, including suggestions for reducing this burden, send them to the Administrator, Wage and Hour Division, U.S. Department of Labor, Room S-3502, 200 Constitution Avenue, NW, Washington, DC 20210.

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