COUNTY OF ALAMEDA

FAMILY AND MEDICAL LEAVES
CERTIFICATION OF HEALTH CARE PROVIDER (SERVICEMEMBER)

Pursuant to the federal Family Medical Leave Act (FMLA), the purpose of this form is to provide sufficient facts to support a request for military family leave due to a serious injury or illness of a covered servicemember; also known as "Military Caregiver Leave." (Note: This leave may also be covered under CFRA.)

For Employee: Please complete Section I (Parts A, B & C) of this form. Be as specific as possible; terms such as "unknown," or indeterminate," may not be sufficient to determine FMLA coverage and may result in a denial of your leave request. Submission of a timely, completed and sufficient certification to support a request for FMLA leave due to a serious injury or illness of a covered servicemember is required to obtain the FMLA benefit. **You must return the required certification to your Human Resources Office within 15 days.**

For Health Care Provider: The employee listed below has requested leave under the FMLA to care for a family member who is a covered servicemember of the Armed Forces with a serious injury or illness as defined by the FMLA and National Defense Authorization Act of 2010. In your best estimate, based upon your medical knowledge, experience and examination, please complete Sections II & III (as appropriate), sign and date this form. Note: Several questions seek a response as to the frequency or duration of a condition, treatment, etc. Please limit your responses to the 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.

SECTION I – TO BE COMPLETED BY EMPLOYEE (PARTS A, B & C)

EMPLOYEE INFORMATION (PART A)

Employee's Name: _____ Employee's ID #: _____

Name of Covered Servicemember: _____

Relationship: ☐Spouse ☐Parent ☐Son ☐Daughter ☐Next of Kin (Relationship): _____

COVERED SERVICEMEMBER INFORMATION (PART B)

1. Is the covered servicemember a current member of the regular Armed Forces, the National Guard or Reserves? ☐Yes ☐No
   - If yes, provide the covered servicemember's military branch, rank and unit currently assigned to:

2. 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? ☐Yes ☐No
   - If yes, provide the name of the medical treatment facility/unit: _____

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

CARE TO BE PROVIDED TO THE COVERED SERVICEMEMBER (PART C)

1. Describe the care to be provided to the covered servicemember and an estimate of the leave needed to provide care:

SECTION II – TO BE COMPLETED BY HEALTH CARE PROVIDER (PARTS D & E)

MEDICAL STATUS OF COVERED SERVICEMEMBER (PART D)

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, you are permitted to rely upon determinations from an authorized DOD representative (such as a DOD recovery care coordinator). Please ensure that Section I above has been completed before completing this section).

MEDICAL STATUS OF COVERED SERVICEMEMBER (PART D - CON'T)

1. Covered servicemember's medical condition is classified as (check appropriate box):

☐ **(VSI) Very Seriously Illness/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 service member 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 Alameda County's Family & Medical Leave (Form 4)

2. Was the condition for which the covered service member is being treated incurred while on covered active duty? ☐ Yes ☐ No

- Approximate date condition commenced: _____. Probable duration of condition and/or need for care: _____.

3. Is the covered service member undergoing medical treatment, recuperation, or therapy? ☐ Yes ☐ No
   - If yes, please describe medical treatment, recuperation or therapy:

COVERED SERVICEMEMBER'S NEED FOR CARE BY FAMILY MEMBER (PART E)

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: _____through _____

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 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:

SECTION III – TO BE COMPLETED BY HEALTH CARE PROVIDER

HEALTH CARE PROVIDER INFORMATION

Health Care Provider's Name **Address**

Type of Practice/Medical Specialty **Telephone & Fax Numbers**

Please state whether you are either a:

1. ☐ **DOD health care provider**
2. ☐ **VA health care provider**
3. ☐ **DOD TRICARE network authorized private health care provider, or**
4. ☐ **DOD non-network TRICARE authorized private health care provider.**

Signature of Health Care Provider **Date**