



HUMAN RESOURCES DEPARTMENT  
FORT BEND COUNTY, TEXAS

Kent M. Edwards, PHR  
Director of Human Resources

To: Judge KP George  
Commissioner Vincent Morales  
Commissioner Grady Prestage  
Commissioner Andy Meyers  
Commissioner Ken DeMerchant

From: Kathy Novosad  
Sr. Human Resources Generalist

Date: August 26, 2020

Subject: Updated FMLA Forms for the Employee Manual

Human Resources is submitting the attached FMLA leave certification forms for the Employee Information Manual, to reflect revisions recently made by the Department of Labor. The revised forms are:

- WH-380-E: Certification of Health Care Provider for Employee's Serious Health Condition
- WH-380-F: Certification of Health Care Provider for Family Member's Serious Health Condition
- WH-384: Certification of Qualifying Exigency for Military Family Leave
- WH-385: Certification for Serious Injury or Illness of Current Service Member for Military Family Leave
- WH-385-V: Certification for Serious Injury or Illness of a Veteran for Military Caregiver Leave

If you have any questions or comments, please contact me at 281-341-8624.

**Certification of Health Care Provider for Employee’s Serious Health Condition under the Family and Medical Leave Act**

**U.S. Department of Labor  
Wage and Hour Division**



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

OMB Control Number: 1235-0003  
Expires: 6/30/2023

The Family and Medical Leave Act (FMLA) provides that an employer may require an employee seeking FMLA protections because of a need for leave due to a serious health condition to submit a medical certification issued by the employee’s health care provider. 29 U.S.C. §§ 2613, 2614(c)(3); 29 C.F.R. § 825.305. The employer must give the employee **at least 15 calendar days** to provide the certification. If the employee fails to provide complete and sufficient medical 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 www.dol.gov/agencies/whd/fmla](http://www.dol.gov/agencies/whd/fmla).

**SECTION I – EMPLOYER**

Either the employee or the employer may complete Section I. While use of this form is optional, this form asks the health care provider for the information necessary for a complete and sufficient medical certification, which is set out at 29 C.F.R. § 825.306. **You may not ask the employee to provide more information than allowed under the FMLA regulations, 29 C.F.R. §§ 825.306-825.308.** Additionally, you **may not** request a certification for FMLA leave to bond with a healthy newborn child or a child placed for adoption or foster care.

Employers must generally maintain records and documents relating to medical information, medical certifications, recertifications, or medical histories of employees 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.

- (1) Employee name: \_\_\_\_\_  
*First Middle Last Employee ID*
- (2) Employer name: \_\_\_\_\_ Date: \_\_\_\_\_ (mm/dd/yyyy)  
*(List date certification requested)*
- (3) The medical certification must be returned by \_\_\_\_\_ (mm/dd/yyyy)  
*(Must allow at least 15 calendar days from the date requested, unless it is not feasible despite the employee’s diligent, good faith efforts.)*
- (4) Employee’s job title: \_\_\_\_\_ Job description (  is /  is not) attached.  
Employee’s regular work schedule: \_\_\_\_\_  
Statement of the employee’s essential job functions: \_\_\_\_\_

*(The essential functions of the employee’s position are determined with reference to the position the employee held at the time the employee notified the employer of the need for leave or the leave started, whichever is earlier.)*

**SECTION II - HEALTH CARE PROVIDER**

Please provide your contact information, complete all relevant parts of this Section, and sign the form. Your patient has requested leave under the FMLA. The FMLA allows an employer to require that the employee submit a timely, complete, and sufficient medical certification to support a request for FMLA leave due to the serious health condition of the employee. For FMLA purposes, a “serious health condition” means an illness, injury, impairment, or physical or mental condition that involves *inpatient care* or *continuing treatment by a health care provider*. For more information about the definitions of a serious health condition under the FMLA, see the chart on page 4.

You may, but are **not required** to, provide other appropriate medical facts including symptoms, diagnosis, or any regimen of continuing treatment such as the use of specialized equipment. Please note that some state or local laws may not allow disclosure of private medical information about the patient’s serious health condition, such as providing the diagnosis and/or course of treatment.

Employee Name: \_\_\_\_\_

Health Care Provider's name: (Print) \_\_\_\_\_

Health Care Provider's business address: \_\_\_\_\_

Type of practice / Medical specialty: \_\_\_\_\_

Telephone: ( ) \_\_\_\_\_ Fax: ( ) \_\_\_\_\_ E-mail: \_\_\_\_\_

**PART A: Medical Information**

Limit your response to the medical condition(s) for which the employee is seeking FMLA leave. Your answers should be your **best estimate** based upon your medical knowledge, experience, and examination of the patient. **After completing Part A, complete Part B to provide information about the amount of leave needed.** Note: For FMLA purposes, "incapacity" means the inability to work, attend school, or perform regular daily activities due to the condition, treatment of the condition, or recovery from the condition. Do not provide information about genetic tests, as defined in 29 C.F.R. § 1635.3(f), genetic services, as defined in 29 C.F.R. § 1635.3(e), or the manifestation of disease or disorder in the employee's family members, 29 C.F.R. § 1635.3(b).

(1) State the approximate date the condition started or will start: \_\_\_\_\_ (mm/dd/yyyy)

(2) Provide your **best estimate** of how long the condition lasted or will last: \_\_\_\_\_

(3) Check the box(es) for the questions below, as applicable. For all box(es) checked, the amount of leave needed must be provided in Part B.

**Inpatient Care:** The patient ( has been /  is expected to be) admitted for an overnight stay in a hospital, hospice, or residential medical care facility on the following date(s): \_\_\_\_\_

**Incapacity plus Treatment:** (e.g. outpatient surgery, strep throat)  
Due to the condition, the patient ( has been /  is expected to be) incapacitated for *more than* three consecutive, full calendar days from \_\_\_\_\_ (mm/dd/yyyy) to \_\_\_\_\_ (mm/dd/yyyy).

The patient ( was /  will be) seen on the following date(s): \_\_\_\_\_

The condition ( has /  has not) also resulted in a course of continuing treatment under the supervision of a health care provider (e.g. prescription medication (other than over-the-counter) or therapy requiring special equipment)

**Pregnancy:** The condition is pregnancy. List the expected delivery date: \_\_\_\_\_ (mm/dd/yyyy).

**Chronic Conditions:** (e.g. asthma, migraine headaches) Due to the condition, it is medically necessary for the patient to have treatment visits at least twice per year.

**Permanent or Long Term Conditions:** (e.g. Alzheimer's, terminal stages of cancer) Due to the condition, incapacity is permanent or long term and requires the continuing supervision of a health care provider (even if active treatment is not being provided).

**Conditions requiring Multiple Treatments:** (e.g. chemotherapy treatments, restorative surgery) Due to the condition, it is medically necessary for the patient to receive multiple treatments.

**None of the above:** If none of the above condition(s) were checked, (i.e., inpatient care, pregnancy) no additional information is needed. Go to page 4 to sign and date the form.

Employee Name: \_\_\_\_\_

- (4) If needed, briefly describe other appropriate medical facts related to the condition(s) for which the employee seeks FMLA leave. (e.g., use of nebulizer, dialysis) \_\_\_\_\_

**PART B: Amount of Leave Needed**

For the medical condition(s) checked in Part A, complete all that apply. 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.

- (5) Due to the condition, the patient ( had /  will have) **planned medical treatment(s)** (scheduled medical visits) (e.g. psychotherapy, prenatal appointments) on the following date(s): \_\_\_\_\_

- (6) Due to the condition, the patient ( was /  will be) **referred to other health care provider(s)** for evaluation or treatment(s).

State the nature of such treatments: (e.g. cardiologist, physical therapy) \_\_\_\_\_

Provide your **best estimate** of the beginning date \_\_\_\_\_ (mm/dd/yyyy) and end date \_\_\_\_\_ (mm/dd/yyyy) for the treatment(s).

Provide your **best estimate** of the duration of the treatment(s), including any period(s) of recovery (e.g. 3 days/week)

- (7) Due to the condition, it is medically necessary for the employee to work a **reduced schedule**.

Provide your **best estimate** of the reduced schedule the employee is able to work. From \_\_\_\_\_ (mm/dd/yyyy) to \_\_\_\_\_ (mm/dd/yyyy) the employee is able to work: (e.g., 5 hours/day, up to 25 hours a week)

- (8) Due to the condition, the patient ( was /  will be) **incapacitated for a continuous period of time**, including any time for treatment(s) and/or recovery.

Provide your **best estimate** of the beginning date \_\_\_\_\_ (mm/dd/yyyy) and end date \_\_\_\_\_ (mm/dd/yyyy) for the period of incapacity.

- (9) Due to the condition, it ( was /  is /  will be) medically necessary for the employee to be absent from work on an **intermittent basis** (periodically), including for any episodes of incapacity i.e., episodic flare-ups. Provide your **best estimate** of how often (frequency) and how long (duration) the episodes of incapacity will likely last.

Over the next 6 months, episodes of incapacity are estimated to occur \_\_\_\_\_ times per ( day /  week /  month) and are likely to last approximately \_\_\_\_\_ ( hours /  days) per episode.

Employee Name: \_\_\_\_\_

**PART C: Essential Job Functions**

If provided, the information in Section I question #4 may be used to answer this question. If the employer fails to provide a statement of the employee’s essential functions or a job description, answer these questions based upon the employee’s own description of the essential job functions. An employee who must be absent from work to receive medical treatment(s), such as scheduled medical visits, for a serious health condition is considered to be *not able* to perform the essential job functions of the position during the absence for treatment(s).

(10) Due to the condition, the employee ( was not able /  is not able /  will not be able) to perform *one or more* of the essential job function(s). Identify at least one essential job function the employee is not able to perform:

\_\_\_\_\_  
\_\_\_\_\_

Signature of Health Care Provider \_\_\_\_\_ Date \_\_\_\_\_ (mm/dd/yyyy)

Definitions of a Serious Health Condition (See 29 C.F.R. §§ 825.113-.115)
<b>Inpatient Care</b>
<ul style="list-style-type: none"><li>• An overnight stay in a hospital, hospice, or residential medical care facility.</li><li>• Inpatient care includes any period of incapacity or any subsequent treatment in connection with the overnight stay.</li></ul>
<b>Continuing Treatment by a Health Care Provider (any one or more of the following)</b>
<p><b><u>Incapacity Plus Treatment:</u></b> A period of incapacity of more than three consecutive, full calendar days, and any subsequent treatment or period of incapacity relating to the same condition, that also involves either:</p> <ul style="list-style-type: none"><li>○ Two or more in-person visits to a health care provider for treatment within 30 days of the first day of incapacity unless extenuating circumstances exist. The first visit must be within seven days of the first day of incapacity; or,</li><li>○ At least one in-person visit to a health care provider for treatment within seven days of the first day of incapacity, which results in a regimen of continuing treatment under the supervision of the health care provider. For example, the health provider might prescribe a course of prescription medication or therapy requiring special equipment.</li></ul>
<p><b><u>Pregnancy:</u></b> Any period of incapacity due to pregnancy or for prenatal care.</p>
<p><b><u>Chronic Conditions:</u></b> Any period of incapacity due to or treatment for a chronic serious health condition, such as diabetes, asthma, migraine headaches. A chronic serious health condition is one which requires visits to a health care provider (or nurse supervised by the provider) at least twice a year and recurs over an extended period of time. A chronic condition may cause episodic rather than a continuing period of incapacity.</p>
<p><b><u>Permanent or Long-term Conditions:</u></b> A period of incapacity which is permanent or long-term due to a condition for which treatment may not be effective, but which requires the continuing supervision of a health care provider, such as Alzheimer’s disease or the terminal stages of cancer.</p>
<p><b><u>Conditions Requiring Multiple Treatments:</u></b> Restorative surgery after an accident or other injury; or, a condition that would likely result in a period of incapacity of more than three consecutive, full calendar days if the patient did not receive the treatment.</p>

**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. 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, N.W., Washington, D.C. 20210.

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

**Certification of Health Care Provider for Family Member’s Serious Health Condition under the Family and Medical Leave Act**

**U.S. Department of Labor  
Wage Hour Division**



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

OMB Control Number: 1235-0003  
Expires: 6/30/2023

The Family and Medical Leave Act (FMLA) provides that an employer may require an employee seeking FMLA leave to care for a family member with a serious health condition to submit a medical certification issued by the family member’s health care provider. 29 U.S.C. §§ 2613, 2614(c)(3); 29 C.F.R. § 825.305. The employer must give the employee **at least 15 calendar days** to provide the certification. If the employee fails to provide complete and sufficient medical 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 www.dol.gov/agencies/whd/fmla](http://www.dol.gov/agencies/whd/fmla).

**SECTION I - EMPLOYER**

Either the employee or the employer may complete Section I. While use of this form is optional, this form asks the health care provider for the information necessary for a complete and sufficient medical certification, which is set out at 29 C.F.R. § 825.306. **You may not ask the employee to provide more information than allowed under the FMLA regulations, 29 C.F.R. §§ 825.306-825.308.** Additionally, you **may not** request a certification for FMLA leave to bond with a healthy newborn child or a child placed for adoption or foster care.

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.

- (1) Employee name: \_\_\_\_\_  
*First*
*Middle*
*Last*
*Employee ID*
- (2) Employer name: \_\_\_\_\_ Date: \_\_\_\_\_ (mm/dd/yyyy)  
*(List date certification requested)*
- (3) The medical certification must be returned by \_\_\_\_\_ (mm/dd/yyyy)  
*(Must allow at least 15 calendar days from the date requested, unless it is not feasible despite the employee’s diligent, good faith efforts.)*

**SECTION II - EMPLOYEE**

Please complete and sign Section II before providing this form to your family member or your family member’s health care provider. The FMLA allows an employer to require that you submit a timely, complete, and sufficient medical certification to support a request for FMLA leave due to the serious health condition of your family member. If requested by your employer, your response is required to obtain or retain the benefit of the FMLA protections. 29 U.S.C. §§ 2613, 2614(c)(3). **You are responsible for making sure the medical certification is provided to your employer within the time frame requested, which must be at least 15 calendar days.** 29 C.F.R. §§ 825.305-825.306. Failure to provide a complete and sufficient medical certification may result in a denial of your FMLA leave request. 29 C.F.R. § 825.313.

- (1) Name of the family member for whom you will provide care: \_\_\_\_\_
- (2) Select the relationship of the family member to you. The family member is your:
  - Spouse
  - Parent
  - Child, under age 18
  - Child, age 18 or older and incapable of self-care because of a mental or physical disability

Spouse means a husband or wife as defined or recognized in the state where the individual was married, including in a common law marriage or same-sex marriage. The terms “child” and “parent” include *in loco parentis* relationships in which a person assumes the obligations of a parent to a child. 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. No legal or biological relationship is necessary.

Employee Name: \_\_\_\_\_

(3) Briefly describe the care you will provide to your family member: *(Check all that apply)*

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

(4) Give your **best estimate** of the amount of leave needed to provide the care described: \_\_\_\_\_  
\_\_\_\_\_

(5) If a **reduced work schedule** is necessary to provide the care described, give your **best estimate** of the reduced schedule you are able to work. From \_\_\_\_\_ (mm/dd/yyyy) to \_\_\_\_\_ (mm/dd/yyyy), I am able to work \_\_\_\_\_ (hours per day) \_\_\_\_\_ (days per week).

Employee Signature \_\_\_\_\_ Date \_\_\_\_\_ (mm/dd/yyyy)

### SECTION III - HEALTH CARE PROVIDER

Please provide your contact information, complete all relevant parts of this Section, and sign the form below. A family member of your patient has requested leave under the FMLA to care for your patient. The FMLA allows an employer to require that the employee submit a timely, complete, and sufficient medical certification to support a request for FMLA leave to care for a family member with a serious health condition. For FMLA purposes, a “serious health condition” means an illness, injury, impairment, or physical or mental condition that *involves inpatient care or continuing treatment by a health care provider*. For more information about the definitions of a serious health condition under the FMLA, see the chart at the end of the form.

You also may, but are **not required** to, provide other appropriate medical facts including symptoms, diagnosis, or any regimen of continuing treatment such as the use of specialized equipment. Please note that some state or local laws may not allow disclosure of private medical information about the patient’s serious health condition, such as providing the diagnosis and/or course of treatment.

Health Care Provider’s name: *(Print)* \_\_\_\_\_

Health Care Provider’s business address: \_\_\_\_\_

Type of practice / Medical specialty: \_\_\_\_\_

Telephone: (\_\_\_\_) \_\_\_\_\_ Fax: (\_\_\_\_) \_\_\_\_\_ E-mail: \_\_\_\_\_

#### **PART A: Medical Information**

Limit your response to the medical condition for which the employee is seeking FMLA leave. Your answers should be your **best estimate** based upon your medical knowledge, experience, and examination of the patient. **After completing Part A, complete Part B to provide information about the amount of leave needed.** Note: For FMLA purposes, “incapacity” means the inability to work, attend school, or perform regular daily activities due to the condition, treatment of the condition, or recovery from the condition. Do not provide information about genetic tests, as defined in 29 C.F.R. § 1635.3(f), genetic services, as defined in 29 C.F.R. § 1635.3(e), or the manifestation of disease or disorder in the employee’s family members, 29 C.F.R. § 1635.3(b).

(1) Patient’s Name: \_\_\_\_\_

(2) State the approximate date the condition started or will start: \_\_\_\_\_ (mm/dd/yyyy)

(3) Provide your **best estimate** of how long the condition lasted or will last: \_\_\_\_\_

(4) For FMLA to apply, care of the patient must be medically necessary. Briefly describe the type of care needed by the patient *(e.g., assistance with basic medical, hygienic, nutritional, safety, transportation needs, physical care, or psychological comfort)*.  
\_\_\_\_\_  
\_\_\_\_\_

Employee Name: \_\_\_\_\_

(5) Check the box(es) for the questions below, as applicable. For all box(es) checked, the amount of leave needed must be provided in Part B.

**Inpatient Care:** The patient ( has been /  is expected to be) admitted for an overnight stay in a hospital, hospice, or residential medical care facility on the following date(s): \_\_\_\_\_

**Incapacity plus Treatment:** (e.g. outpatient surgery, strep throat)

Due to the condition, the patient ( has been /  is expected to be) incapacitated for *more than three* consecutive, full calendar days from \_\_\_\_\_ (mm/dd/yyyy) to \_\_\_\_\_ (mm/dd/yyyy).

The patient ( was /  will be) seen on the following date(s): \_\_\_\_\_

The condition ( has /  has not) also resulted in a course of continuing treatment under the supervision of a health care provider (e.g. prescription medication (other than over-the-counter) or therapy requiring special equipment)

**Pregnancy:** The condition is pregnancy. List the expected delivery date: \_\_\_\_\_ (mm/dd/yyyy).

**Chronic Conditions:** (e.g. asthma, migraine headaches) Due to the condition, it is medically necessary for the patient to have treatment visits at least twice per year.

**Permanent or Long Term Conditions:** (e.g. Alzheimer's, terminal stages of cancer) Due to the condition, incapacity is permanent or long term and requires the continuing supervision of a health care provider (even if active treatment is not being provided).

**Conditions requiring Multiple Treatments:** (e.g. chemotherapy treatments, restorative surgery) Due to the condition, it is medically necessary for the patient to receive multiple treatments.

**None of the above:** If none of the above condition(s) were checked, (i.e., inpatient care, pregnancy) no additional information is needed. Go to page 4 to sign and date the form.

(6) If needed, briefly describe other appropriate medical facts related to the condition(s) for which the employee seeks FMLA leave. (e.g., use of nebulizer, dialysis) \_\_\_\_\_

### **PART B: Amount of Leave Needed**

For the medical condition(s) checked in Part A, complete all that apply. 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 if the benefits and protections of the FMLA apply.

(7) Due to the condition, the patient ( had /  will have) **planned medical treatment(s)** (scheduled medical visits) (e.g. psychotherapy, prenatal appointments) on the following date(s): \_\_\_\_\_

(8) Due to the condition, the patient ( was /  will be) **referred to other health care provider(s)** for evaluation or treatment(s).

State the nature of such treatments: (e.g. cardiologist, physical therapy) \_\_\_\_\_

Provide your **best estimate** of the beginning date \_\_\_\_\_ (mm/dd/yyyy) and end date \_\_\_\_\_ (mm/dd/yyyy) for the treatment(s).

Provide your **best estimate** of the duration of the treatment(s), including any period(s) of recovery \_\_\_\_\_ (e.g. 3 days/week)

Employee Name: \_\_\_\_\_

- (9) Due to the condition, the patient ( was /  will be) **incapacitated for a continuous period of time**, including any time for treatment(s) and/or recovery.

Provide your **best estimate** of the beginning date: \_\_\_\_\_ (mm/dd/yyyy) and end date \_\_\_\_\_ (mm/dd/yyyy) for the period of incapacity.

- (10) Due to the condition it, ( was /  is /  will be) medically necessary for the employee to be absent from work to provide care for the patient on an **intermittent basis** (periodically), including for any episodes of incapacity i.e., episodic flare-ups. Provide your **best estimate** of how often (frequency) and how long (duration) the episodes of incapacity will likely last.

Over the next 6 months, episodes of incapacity are estimated to occur \_\_\_\_\_ times per ( day /  week /  month) and are likely to last approximately \_\_\_\_\_ ( hours /  days) per episode.

Signature of Health Care Provider \_\_\_\_\_ Date \_\_\_\_\_ (mm/dd/yyyy)

Definitions of a Serious Health Condition (See 29 C.F.R. §§ 825.113-.115)
<b>Inpatient Care</b>
<ul style="list-style-type: none"><li>• An overnight stay in a hospital, hospice, or residential medical care facility.</li><li>• Inpatient care includes any period of incapacity or any subsequent treatment in connection with the overnight stay.</li></ul>
<b>Continuing Treatment by a Health Care Provider (any one or more of the following)</b>
<p><b><u>Incapacity Plus Treatment:</u></b> A period of incapacity of more than three consecutive, full calendar days, and any subsequent treatment or period of incapacity relating to the same condition, that also involves either:</p> <ul style="list-style-type: none"><li>○ Two or more in-person visits to a health care provider for treatment within 30 days of the first day of incapacity unless extenuating circumstances exist. The first visit must be within seven days of the first day of incapacity; or,</li><li>○ At least one in-person visit to a health care provider for treatment within seven days of the first day of incapacity, which results in a regimen of continuing treatment under the supervision of the health care provider. For example, the health provider might prescribe a course of prescription medication or therapy requiring special equipment.</li></ul>
<p><b><u>Pregnancy:</u></b> Any period of incapacity due to pregnancy or for prenatal care.</p>
<p><b><u>Chronic Conditions:</u></b> Any period of incapacity due to or treatment for a chronic serious health condition, such as diabetes, asthma, migraine headaches. A chronic serious health condition is one which requires visits to a health care provider (or nurse supervised by the provider) at least twice a year and recurs over an extended period of time. A chronic condition may cause episodic rather than a continuing period of incapacity.</p>
<p><b><u>Permanent or Long-term Conditions:</u></b> A period of incapacity which is permanent or long-term due to a condition for which treatment may not be effective, but which requires the continuing supervision of a health care provider, such as Alzheimer’s disease or the terminal stages of cancer.</p>
<p><b><u>Conditions Requiring Multiple Treatments:</u></b> Restorative surgery after an accident or other injury; or, a condition that would likely result in a period of incapacity of more than three consecutive, full calendar days if the patient did not receive the treatment.</p>

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**Certification for Military Family Leave for Qualifying Exigency under the Family and Medical Leave Act**

**U.S. Department of Labor  
Wage and Hour Division**



**DO NOT SEND FORM TO THE DEPARTMENT OF LABOR.  
RETURN THE COMPLETED FORM TO THE EMPLOYER.**

OMB Control Number: 1235-0003  
Expires: 6/30/2023

The Family and Medical Leave Act (FMLA) provides that eligible employees may take FMLA leave for a qualifying exigency while the employee's spouse, child, or parent (the military member) is on covered active duty or has been notified of an impending call or order to covered active duty. The FMLA allows an employer to require an employee seeking FMLA leave due to a qualifying exigency to submit a certification. 29 U.S.C. §§ 2613, 2614(c)(3). The employer must give the employee **at least 15 calendar days** to provide the certification. 29 C.F.R. § 825.305(b). If the employee fails to provide complete and sufficient certification, the employee's 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/agencies/whd/fmla](http://www.dol.gov/agencies/whd/fmla).

**SECTION I - EMPLOYER**

Either the employee or the employer may complete Section I. While use of this form is optional, it asks the employee for the information necessary for a complete and sufficient qualifying exigency certification, which is set out at 29 C.F.R. § 825.309. **You may not ask the employee to provide more information than allowed under the FMLA regulations, 29 C.F.R. § 825.309.**

- (1) Employee name: \_\_\_\_\_  
*First Middle Last Employee ID*
- (2) Employer name: \_\_\_\_\_ Date: \_\_\_\_\_ (mm/dd/yyyy)  
*(List date certification requested)*
- (3) This certification must be returned by \_\_\_\_\_ (mm/dd/yyyy).  
*(Must allow at least 15 calendar days from the date requested, unless it is not feasible despite the employee's diligent, good faith efforts.)*

**SECTION II - EMPLOYEE**

Please complete all Parts of Section II and sign the form before returning it to your employer. The FMLA allows an employer to require that you submit a timely, complete, and sufficient certification to support a request for FMLA leave due to a qualifying exigency. If requested by your employer, your response is required to obtain the benefits and protections of the FMLA. 29 C.F.R. § 825.309. Failure to provide a complete and sufficient certification may result in a denial of your FMLA leave request. A complete and sufficient certification to support a request for FMLA leave due to a qualifying exigency includes written documentation confirming a military member's covered active duty or call to covered active duty status. **You are responsible for making sure the certification is provided to your employer within the time frame requested, which must be at least 15 calendar days.** 29 C.F.R. § 825.313.

- (1) Provide the name of the military member on covered active duty or call to covered active duty status:  
\_\_\_\_\_  
*First Middle Last*
- (2) Select your relationship of the military member. The military member is your:  
 Spouse     Parent     Child, of any age

Spouse means a husband or wife as defined or recognized in the state where the individual was married, including a common law marriage or same-sex marriage. The terms "child" and "parent" include *in loco parentis* relationships in which a person assumes the obligations of a parent to a child. An employee may take FMLA leave for a qualifying exigency related a military member who assumed the obligations of a parent to the employee when the employee was a child. An employee may also take FMLA leave for a qualifying exigency related a military member for whom the employee has assumed the obligations of a parent. No legal or biological relationship is necessary.

Employee Name: \_\_\_\_\_

**PART A: COVERED ACTIVE DUTY STATUS**

Covered active duty or call to covered active duty in the case of a member of the Regular Armed Forces means duty during the deployment of the member with the Armed Forces to a foreign country. Covered active duty or call to covered active duty in the case of a member of the Reserve components means duty during the deployment of the member with the Armed Forces to a foreign country under a Federal call or order to active duty in support of a contingency operation pursuant to: Section 688 of Title 10 of the United States Code; Section 12301(a) of Title 10 of the United States Code; Section 12302 of Title 10 of the United States Code; Section 12304 of Title 10 of the United States Code; Section 12305 of Title 10 of the United States Code; Section 12406 of Title 10 of the United States Code; chapter 15 of Title 10 of the United States Code; or, any other provision of law during a war or during a national emergency declared by the President or Congress so long as it is in support of a contingency operation. 10 U.S.C. § 101(a)(13)(B).

An employer may require the employee to provide a copy of the military member's active duty orders or other documentation issued by the military which indicates that the military member is on covered active duty or call to covered active duty status, and the dates of the military member's covered active duty service. **This information need only be provided to the employer once, unless additional leave is needed for a different military member or different deployment.**

- (3) Provide the dates of the military member's covered active duty service: \_\_\_\_\_
- (4) Please check one of the following and attach the indicated written document to support that the military member is on covered active duty or call to covered active duty status:
  - A copy of the military member's covered active duty orders
  - Other documentation from the military indicating that the military member is on covered active duty or has been notified of an impending call to covered active duty, such as official military correspondence from the military member's chain of command
  - I have previously provided my employer with sufficient written documentation confirming the military member's covered active duty or call to covered active duty status

**PART B: APPROPRIATE FACTS**

Under the FMLA, leave can be taken for a number of qualifying exigencies. 29 C.F.R. § 825.126(b). Complete and sufficient certification to support a request for FMLA leave due to a qualifying exigency includes available written documentation which supports the need for leave such as a copy of a meeting announcement for informational briefings sponsored by the military, a document confirming the military member's Rest and Recuperation leave, or other documentation issued by the military which indicates that the military member has been granted Rest and Recuperation leave, or a document confirming an appointment with a third party (e.g., a counselor or school official, or staff at a care facility, a copy of a bill for services for the handling of legal or financial affairs). Please provide appropriate facts related to the particular qualifying exigency to support the FMLA leave request, including information on the type of qualifying exigency and any available written documentation of the exigency event.

- (5) Select the appropriate **Qualifying Exigency Category** and, if needed, provide additional information related to the event:
  - Short notice deployment (*i.e.*, deployment within seven or fewer days of notice)
  - Military events and related activities (*e.g.*, *official ceremonies or events, or family support and assistance programs*):  
\_\_\_\_\_
  - Childcare related activities for the child of the military member (*e.g.*, *arranging for alternative childcare*):  
\_\_\_\_\_

Employee Name: \_\_\_\_\_

- Care for the military member's parent (e.g., admitting or transferring the parent to a new care facility):  
\_\_\_\_\_
- Financial and legal arrangements related to the deployment (e.g., obtaining military identification cards)
- Counseling related to the deployment (i.e., counseling provided by someone other than a health care provider)
- Military member's short-term, temporary Rest and Recuperation leave (R&R) (leave for this reason is limited to 15 calendar days for each instance of R&R)
- Post deployment activities (e.g., arrival ceremonies, or reintegration briefings and events): \_\_\_\_\_
- Any other event that the employee and employer agree is a qualifying exigency: \_\_\_\_\_

(6) Available written documentation supporting this request for leave is ( attached /  not attached /  not available).

**PART C: AMOUNT OF LEAVE NEEDED**

Provide information concerning the amount of leave that will be needed. Several questions in this section seek a response as to the frequency or duration of the qualifying exigency leave needed. Be as specific as you can; terms such as "unknown" or "indeterminate" may not be sufficient to determine FMLA coverage.

(7) List the approximate date exigency started or will start: \_\_\_\_\_ (mm/dd/yyyy)

(8) Provide your best estimate of how long the exigency lasted or will last:

From \_\_\_\_\_ (mm/dd/yyyy) to \_\_\_\_\_ (mm/dd/yyyy)

(9) Due to a qualifying exigency, I need to work a **reduced schedule**. Provide your **best estimate** of the reduced schedule you are able to work:

From \_\_\_\_\_ (mm/dd/yyyy) to \_\_\_\_\_ (mm/dd/yyyy)

I am able to work \_\_\_\_\_  
(e.g., 5 hours/day, up to 25 hours a week)

(10) Due to a qualifying exigency, I will need to be absent from work for a **continuous period of time**. Provide your **best estimate** of the beginning and ending dates for the period of absence:

From \_\_\_\_\_ (mm/dd/yyyy) to \_\_\_\_\_ (mm/dd/yyyy)

Employee Name: \_\_\_\_\_

(11) Due to a qualifying exigency, I will need to be absent from work on an **intermittent basis** (periodically).

Provide your **best estimate** of the frequency (how often) and duration (how long) of each appointment, meeting, or leave event, including any travel time.

Over the next 6 months, absences on an **intermittent basis** are estimated to occur: \_\_\_\_\_ times per  
( day /  week /  month) and are likely to last approximately \_\_\_\_\_ ( hours /  days) per episode.

(12) My leave is due to a qualifying exigency that involves **Rest and Recuperation leave** (R & R) of the military member (leave for this reason is limited to 15 calendar days for each instance of R & R leave).

List the dates of the military member's R & R leave:

From \_\_\_\_\_ (mm/dd/yyyy) to \_\_\_\_\_ (mm/dd/yyyy)

#### **PART D: THIRD PARTY INFORMATION**

If applicable, please provide information below that may be used by your employer to verify meetings or appointments with a third party related to the qualifying exigency. Examples of meetings with third parties include: arranging for childcare or parental care, to attend non-medical counseling, to attend meetings with school, childcare or parental care providers, to make financial or legal arrangements, to act as the military member's representative before a federal, state, or local agency for purposes of obtaining, arranging or appealing military service benefits, or to attend any event sponsored by the military or military service organizations. This information may be used by your employer to verify that the information contained on this form is accurate.

Individual (e.g., name and title) or Entity / Organization: \_\_\_\_\_

Address: \_\_\_\_\_

Telephone: (\_\_\_\_) \_\_\_\_\_ Fax: (\_\_\_\_) \_\_\_\_\_ E-mail: \_\_\_\_\_

Describe purpose of meeting: \_\_\_\_\_

Employee  
Signature \_\_\_\_\_ Date \_\_\_\_\_ (mm/dd/yyyy)

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#### **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. 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, N.W., Washington, D.C. 20210.

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**DO NOT SEND THE COMPLETED FORM TO THE DEPARTMENT OF DEPARTMENT OF LABOR.  
RETURN FORM TO THE EMPLOYER.**

**Certification for Serious Injury or Illness of a  
Current Servicemember for Military Caregiver Leave  
under the Family and Medical Leave Act**

**U.S. Department of Labor  
Wage Hour Division**



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

OMB Control Number: 1235-0003  
Expires: 6/30/2023

The Family and Medical Leave Act (FMLA) provides that eligible employees may take FMLA leave to care for a covered servicemember with a serious illness or injury. The FMLA allows 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** to provide the certification. If the employee fails 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 www.dol.gov/agencies/whd/fmla](http://www.dol.gov/agencies/whd/fmla).

## SECTION I - EMPLOYER

Either the employee or the employer may complete Section I. While use of this form is optional, it asks the health care provider for the information necessary for a complete and sufficient medical certification. **You may not ask the employee to provide more information than allowed under the FMLA regulations, 29 C.F.R. § 825.310. Recertifications are not allowed for FMLA leave to care for a covered servicemember. 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.** An employer requiring an employee to submit a certification for leave to care for a covered servicemember **must** accept as sufficient certification invitational travel orders (ITOs) or invitational travel authorizations (ITAs) issued to any family member to join an injured or ill servicemember at the servicemember's bedside. An ITO or ITA is sufficient certification for the duration of time specified in the ITO or ITA.

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.

- (1) Employee name: \_\_\_\_\_  
*First*
*Middle*
*Last*
*Employee ID*
- (2) Employer name: \_\_\_\_\_ Date: \_\_\_\_\_ (mm/dd/yyyy)  
*(List date certification requested)*
- (3) This certification must be returned by: \_\_\_\_\_ (mm/dd/yyyy)  
*(Must allow at least 15 calendar days from the date requested, unless it is not feasible despite the employee's diligent, good faith efforts.)*

## SECTION II - EMPLOYEE and/or CURRENT SERVICEMEMBER

Please complete all Parts of Section II before having the servicemember's health care provider complete Section III. The FMLA allows 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 covered servicemember. If requested by your employer, your response is required to obtain or retain the benefit of FMLA-protected leave.

### **PART A: EMPLOYEE INFORMATION**

- (1) Name of the current servicemember for whom employee is requesting leave: \_\_\_\_\_

**Employee Name:** \_\_\_\_\_

(2) Select your relationship to the current servicemember. You are the current servicemember's:

- Spouse                       Parent                       Child                       Next of Kin

Spouse means a husband or wife as defined or recognized in the state where the individual was married, including a common law marriage or same-sex marriage. The terms "child" and "parent" include *in loco parentis* relationships in which a person assumes the obligations of a parent to a child. 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. No biological or legal relationship is necessary. "Next of kin" is the servicemember'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 servicemember for purposes of FMLA leave, (2) blood relatives granted legal custody of the servicemember, (3) brothers and sisters, (4) grandparents, (5) aunts and uncles, and (6) first cousins.

**PART B: SERVICEMEMBER INFORMATION AND CARE TO BE PROVIDED TO THE SERVICEMEMBER**

(3) The servicemember ( is /  is not) a current member of the Regular Armed Forces, the National Guard or Reserves. If yes, provide the servicemember's military branch, rank and unit currently assigned to: \_\_\_\_\_

(4) The servicemember ( is /  is not) 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: \_\_\_\_\_

(5) The servicemember ( is /  is not) on the Temporary Disability Retired List (TDRL).

(6) Briefly describe the care you will provide to the servicemember: *(Check all that apply)*

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

(7) Give your **best estimate** of the amount of leave needed to provide the care described: \_\_\_\_\_

(8) If a reduced work schedule is necessary to provide the care described, give your **best estimate** of the reduced work schedule you are able to work. From \_\_\_\_\_ (mm/dd/yyyy) to \_\_\_\_\_ (mm/dd/yyyy), I am able to work: \_\_\_\_\_ (hours per day) \_\_\_\_\_ (days 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. The employee listed at Section I 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. Note: 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 the servicemember's office, grade, rank, or rating. "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 servicemember is not able to care for his or her own basic medical, hygienic, or nutritional needs or safety, or needs transportation to the doctor. It also includes providing psychological comfort and reassurance which would be beneficial to the servicemember who is receiving inpatient or home

**Employee Name:** \_\_\_\_\_

care. 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.

**PART A: HEALTH CARE PROVIDER INFORMATION**

Health Care Provider's Name: *(Print)* \_\_\_\_\_

Health Care Provider's business address: \_\_\_\_\_

Type of practice/Medical specialty: \_\_\_\_\_

Telephone: (\_\_\_\_) \_\_\_\_\_ Fax: (\_\_\_\_) \_\_\_\_\_ E-mail: \_\_\_\_\_

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
- Health care provider as defined in 29 C.F.R. § 825.125

**PART B: MEDICAL INFORMATION**

Please provide appropriate medical information of the patient as requested below. Limit your responses to the servicemember's condition for which the employee is seeking leave. If you are unable to make some 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. 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).

(1) Patient's Name: \_\_\_\_\_

(2) List the approximate date condition started or will start: \_\_\_\_\_ *(mm/dd/yyyy)*

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

(4) The servicemember's injury or illness: *(Select as appropriate)*

- Was incurred in the line of duty on active duty.
- Existed before the beginning of the servicemember's active duty and was aggravated by service in the line of duty on active duty.
- None of the above.

(5) The servicemember ( is /  is not) undergoing medical treatment, recuperation, or therapy for this condition.

If yes, briefly describe the medical treatment, recuperation or therapy: \_\_\_\_\_

Employee Name: \_\_\_\_\_

- (6) The current servicemember's medical condition is classified as: *(Select as appropriate)*
- (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 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.*

**PART C: AMOUNT OF LEAVE NEEDED**

For the medical condition checked in Part B, complete all that apply. Some 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.

- (7) Due to the condition, the servicemember will need care for a **continuous period of time**, including any time for treatment and recovery. Provide your **best estimate** of the beginning date \_\_\_\_\_ (mm/dd/yyyy) and end date \_\_\_\_\_ (mm/dd/yyyy) for this period of time.
- (8) Due to the condition, it is medically necessary for the servicemember to attend **planned medical treatment** appointments (scheduled medical visits). Provide your **best estimate** of the duration of the treatment(s), including any period(s) of recovery \_\_\_\_\_ (e.g. 3 days/week)
- (9) Due to the condition, it is medically necessary for the servicemember 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 servicemember's recovery. Provide your **best estimate** of how often (frequency) and how long (the duration) the intermittent episodes will likely last.

Over the next 6 months, intermittent care is estimated to occur \_\_\_\_\_ times per  
( day /  week /  month) and are likely to last approximately \_\_\_\_\_ ( hours /  days) per episode.

**Signature of Health Care Provider** \_\_\_\_\_ **Date** \_\_\_\_\_ (mm/dd/yyyy)

**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, N.W., Washington, D.C. 20210.

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

Certification for Serious Injury or Illness of a Veteran for Military Caregiver Leave (Family and Medical Leave Act)

U.S. Department of Labor



DO NOT SEND COMPLETED FORM TO THE DEPARTMENT OF LABOR; RETURN TO THE EMPLOYEE

OMB Control Number: 1235-0003 Expires: 8/31/2021

Notice 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. 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 CFR 825.310. 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, and in accordance with 29 CFR 1635.9, if the Genetic Information Nondiscrimination 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.

(This section must be completed before Section II 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 a veteran):

\_\_\_\_\_

Name of employee requesting leave to care for a veteran:

\_\_\_\_\_
First Middle Last Employee ID

Name of veteran (for whom employee is requesting leave):

\_\_\_\_\_
First Middle Last

Relationship of employee to veteran:

Spouse [ ] Parent [ ] Son [ ] Daughter [ ] Next of Kin [ ] (please specify relationship):

**Part B: VETERAN INFORMATION**

- (1) Date of the veteran's discharge:  
\_\_\_\_\_
- (2) Was the veteran **dishonorably** discharged or released from the Armed Forces (including the National Guard or Reserves)? Yes  No
- (3) Please provide the veteran's military branch, rank and unit at the time of discharge:  
\_\_\_\_\_
- (4) Is the veteran receiving medical treatment, recuperation, or therapy for an injury or illness?  
Yes  No

**Part C: CARE TO BE PROVIDED TO THE VETERAN**

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

\_\_\_\_\_  
\_\_\_\_\_

**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:

- (i) 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
- (ii) 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
- (iii) 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
- (iv) 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 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 military caregiver leave coverage. 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 CFR 1635.3(f), or genetic services, as defined in 29 CFR 1635.3(e).

(Please ensure that Section I has been completed before completing this section. Please be sure to sign the form on the last page and return this form to the employee requesting leave (See Section I, Part A above). **DO NOT SEND THE COMPLETED FORM TO THE WAGE AND HOUR DIVISION.**)

**Part A: HEALTH CARE PROVIDER INFORMATION**

Health care provider’s name and business address:

\_\_\_\_\_

Telephone: ( ) \_\_\_\_\_ Fax: ( ) \_\_\_\_\_ Email: \_\_\_\_\_

Type of Practice/Medical Specialty: \_\_\_\_\_

Please indicate if you are:

a DOD health care provider

a VA health care provider

a DOD TRICARE network authorized private health care provider

a DOD non-network TRICARE authorized private health care provider

other health care provider

704-25

**PART B: MEDICAL STATUS**

Note: 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.

(1) The Veteran’s medical condition 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.
- 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.

(2) 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 Forces? Yes  No

(3) Approximate date condition commenced: \_\_\_\_\_

(4) Probable duration of condition and/or need for care: \_\_\_\_\_

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

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

\_\_\_\_\_

**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.

(1) Will the veteran 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 veteran require periodic follow-up treatment appointments? Yes  No

If yes, estimate the treatment schedule: \_\_\_\_\_

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

If yes, please estimate the frequency and duration of the periodic care:

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Signature of Health Care Provider: \_\_\_\_\_ Date: \_\_\_\_\_

**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 CFR 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 20 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 Ave., NW, Washington, DC 20210. **DO NOT SEND THE COMPLETED FORM TO THE WAGE AND HOUR DIVISION; RETURN IT TO THE EMPLOYEE REQUESTING LEAVE (As shown in Section I, Part "A" above).**