

Employee Name: _____

“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 needs transportation 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 www.dol.gov/agencies/whd/fmla](http://www.dol.gov/agencies/whd/fmla).

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 CFR 825.125

PART B: MEDICAL INFORMATION

Please provide appropriate medical information of the patient as requested below. Limit your responses to the veteran’s condition for which the employee is seeking leave. 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. 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 veteran’s injury or illness: *(Select as appropriate)*

- 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
- None of the above

The veteran (is / is not) undergoing medical treatment, recuperation, or therapy for this condition. If yes, briefly describe the medical treatment, recuperation, or therapy: _____

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(5) 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.*

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 military caregiver leave coverage.

- (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 date _____ (mm/dd/yyyy) and end date _____ (mm/dd/yyyy) for this period of time.
- (2) Due to the condition, it is medically necessary for the veteran 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)
- (3) Due to the condition, it is medically necessary 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 often (frequency) and how long (duration) the episodes of incapacity 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, NW, Washington, DC 20210.

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