MEDICAL CERTIFICATION FOR CARE OF A CURRENT SERVICE MEMBER/VETERAN WITH SERIOUS INJURY/ILLNESS

Please return completed forms to Absence Management
14201 School Lane, Room 132 Upper Marlboro, MD 20772
Phone: 301-952-6200 Fax: 301-760-3593 Email: absence.mgmt@pgcps.org

SECTION I: TO BE COMPLETED BY THE EMPLOYEE: EXTENDED LEAVE REQUEST FORM (Required)
I have completed and attached the EXTENDED LEAVE REQUEST FORM. ___Yes ___No

To qualify for FMLA entitlements, you must submit a complete, sufficient, and timely medical certification to support your leave request under FMLA. 29 U.S.C. §§ 2613, 2614(c)(3). Failure to provide sufficient medical certification will result in the denial of your FMLA request. Please return this form to Absence Management within 15 calendar days. ***The employee should complete Section II before giving this form to the treating health care provider.***

By signing below, I authorize all treating healthcare provider(s) to release information obtained in the course of the evaluation and treatment of my family member to Absence Management. Further, I grant Absence Management permission to verify all supporting documents in order to determine my eligibility and entitlement for medical leave.

SECTION II: TO BE COMPLETED BY THE EMPLOYEE

SECTION II, PART A: EMPLOYEE INFORMATION

Employee's Name: _____EIN: _____
First Middle Last

Work Organization: _____ Job Title: _____

Do you elect to use your projected leave? __ **Y**es __ **N**o.

Name of Current servicemember/Veteran for whom employee will provide care: ----------

Relationship of servicemember/Veteran to employee: _____Spouse _____Parent ____Son ____ Daughter

_____Next of Kin **Your relationship to covered military member**:_____

If family member is your son or daughter, date of birth: _____

SECTION II, PART B: SERVICEMEMBER INFORMATION (If a veteran, proceed to Part C)

1. Is the servicemember a current member of the Regular Armed Forces, the National Guard, or Reserves?
   ____**Y**es __ **N**o.
   If yes, please provide the service member's military branch, rank and unit of current assignment:

   _____

2. Is the service member 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)? ____ **Y**es ____**N**o.

   If yes, please provide the name of the medical treatment facility or unit: _____

3. Is the service member on the Temporary Disability Retired List (TDRL)? _____ **Y**es ____ **N**o.

SECTION II, PART C: VETERAN INFORMATION

1. Date of discharge from active duty: _____

2. Was the veteran dishonorably discharged or released from the Armed Forces (including the National Guard or Reserves)? ___Yes ____ No. **(Form DD214 required)**

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? ___**Y**es ___**N**o.

I must submit or a Letter of Intent to Return to Work to Absence Management 10 days before the end date of an approved leave and receive a letter of Eligibility to Return to Work prior to returning to work.

Employee Signature: _____ ***Home Phone #:*** _____ ***Date:*** _____

SECTION III: TO BE COMPLETED BY THE TREATING HEALTHCARE PROVIDER: *The employee listed above has requested leave under the FMLA to care for your patient, a current service member or veteran with serious injury/illness. Where indicated, your documentation should provide specific dates. Terms such as, "lifetime," "unknown," or "unable to determine" will not be sufficient to determine eligibility for a FMLA. If medical decision requires documentation of uncertain frequency and uncertain duration of a condition, your best estimation of time and frequency is required. If needed, utilize the last page for further documentation.* **Please note that this form applies to both active service member and veteran. Below, choose option(s) that best describe you.**

___A United States Department of Defense ("DOD") health care provider;
___A United States Department of Veterans Affairs ("VA") health care provider;
___ A DOD TRICARE network authorized private health care provider;
___ A DOD non-network TRICARE authorized private health care provider; or
___ A health care provider as defined in 29 CFR 825.125.

SECTION III, PART A: THE PATIENT'S MEDICAL FACTS (Required)

Diagnosis	ICD-9 - Code(s)	ICD-10 - Code(s)	Signs & Symptoms of the serious health condition	List duties & care the employee will provide to your patient

Severity of Illness/Injury Condition ☐ **Mild** ☐ **Moderate** ☐ **Severe**
Acuity of Injury/Illness Condition ☐ **Acute** ☐ **Chronic** ☐ **Acute exacerbation**

SECTION III, PART B: THE SERVICEMEMBER INJURY/ILLNESS CLASSIFICATION*: (Proceed to Part C if completing for a veteran). Please check the box that applies.*

	Very Seriously Ill/Injured (VSI) – Illness/Injury is of such a severity that life is imminently endangered. Family members are requested at bedside immediately.
	Seriously Ill/Injured (SI) – 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.
	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**. If appropriate, please request such leave and complete the FMLA form for covered family member with a serious health condition.

1. Is the current service member being treated for a condition which was incurred or aggravated by service in the line of duty on active duty in the Armed Forces? ___**Y**es ___**N**o.
2. Approximate date condition commenced: _____
3. What is the usual recovery period for this condition? _____
4. Is the service member undergoing medical treatment, recuperation, or therapy for this condition? ___ **Y**es ___ **N**o.

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

SECTION III, PART C: THE VETERAN INJURY/ILLNESS CLASSIFICATION:

Please check the box that applies

	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 service member 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

1. Is the veteran being treated for a condition that was incurred or aggravated by service in the line of an active duty in the Armed Forces? ___**Y**es ___**N**o.
2. Approximate date condition commenced: _____
3. Probable duration of condition and/or need for care: _____
4. Is the veteran undergoing medical treatment, recuperation, or therapy for this serious illness/injury? ___**Y**es ___**N**o.

SECTION III, PART D: SERVICEMEMBER/VETERAN NEED FOR CARE BY FAMILY MEMBER: *Please select option one or two*

☐ **Option 1**

Will the employee/caretaker need a single continuous period of temporary absence, including any time for treatment and recovery? ___ Yes ___ No. If yes, Beginning Date: _____ Ending Date: _____

☐ **Option 2**

Will the condition cause episodic flare-ups requiring employee/caretaker to need intermittent periods of absence to provide medically necessary care? ____Yes ____ No

If yes, estimate the frequency of flare-ups and the duration of related incapacity over the next 6 months –

# of hours per day: _____ # of days per week: _____or # of days per month: _____

Upon Returning to Work -

Will the employee/caretaker need to attend follow-up treatment appointments because of this serious health condition? ____Yes _____No If yes, List treatment schedule: _____

SPACE FOR AN ADDITIONAL DOCUMENTATION

_____

_____

I declare under penalty of perjury that I have examined all the information on this form, and on any accompanying statements or forms, and it is true and correct to the best of my knowledge. I understand that anyone who knowingly gives a false or misleading statement about a material fact in this information, or causes someone else to do so, commits a crime and may be sent to prison, or may face other penalties, or both.

Healthcare Provider's Name: _____ *(PRINT)* ***National Provider ID #:*** _____ ***(Required)***

Business Address: _____

Telephone: ( ) _____ Fax: ( ): _____ Practice Specialty: _____ (Required)

Signature of Healthcare Provider: _____ ***(No Stamp)*** ***Date:*** _____ ***(Required)***