UNIVERSITY OF WISCONSIN SYSTEM
CERTIFICATION OF SERIOUS INJURY OR ILLNESS OF A CURRENT SERVICEMEMBER OR VETERAN
FOR MILITARY CAREGIVER LEAVE
(FAMILY AND MEDICAL LEAVE ACT)

SECTION 1: For completion by the EMPLOYER
Name of UW Institution:
Name of Employer Contact:
Address of Employer:
Employer Contact Phone/Email:
SECTION 2: For completion by the EMPLOYEE and/or the CURRENT SERVICEMEMBER or VETERAN for whom the Employee is Requesting Leave
INSTRUCTIONS FOR SECTION 2: Sections 1 and 2 must be completed before Section 3. If requested by the employer, your response is required to obtain or retain the benefit of FMLA protections. Failure to provide a sufficient certification may result in a denial of your FMLA request. Your employer must give you at least 15 calendar days to return this form to your employer.
Part A: EMPLOYEE INFORMATION
Employee Name:
Name of Current Servicemember or Veteran Who Needs Care:
Relationship of Current Servicemember or Veteran to Employee: ☐ Spouse ☐ Parent ☐ Son ☐ Daughter ☐ Next of Kin**(see last page for definition)*
The person who needs care is a ☐ Current Member of the Armed Forces (go to Part B of Section 2) or a ☐ Veteran of the Armed Forces (go to Part C of Section 2).
Part B: CURRENT SERVICEMEMBER INFORMATION (only complete if person who needs care is a current member of the Armed Forces)
1. Is the servicemember a current member of the regular Armed Forces, National Guard or Reserves? ☐ Yes ☐ No If yes, enter the servicemember's military branch, rank and unit: _____ 2. Is the 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, enter the name of the medical treatment facility or unit: _____ 3. Is the covered servicemember on the Temporary Disability Retired List (TDRL)? ☐ Yes ☐ No

Part C: VETERAN INFORMATION (only complete if person who needs care is a veteran of the Armed Forces)

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 D: CARE TO BE PROVIDED TO THE CURRENT SERVICEMEMBER OR VETERAN

Describe the care to be provided to the current servicemember or veteran and provide an estimate of the length of leave needed to provide the care:

SECTION 3: 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; (3) a DOD non-network Tricare authorized private health care provider; or (4) a health care provider as defined in 29 CFR 825.125. If you are unable to make certain of the military-related determinations contained in Part B of Section 3, you are permitted to rely upon determinations from an authorized DOD representative (such as a DOD recovery care coordinator). Please ensure that Sections 1 and 2 have been completed before completing this section.

INSTRUCTIONS FOR HEALTH CARE PROVIDER:

Please answer all questions relative to the current servicemember or veteran listed in Section 2 as fully and completely as possible. There are questions that require answers about the frequency and duration of a condition or treatment. 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. Please complete all parts of Section 3 (Parts A-D) and sign the last page of the form.

Part A: HEALTH CARE PROVIDER INFORMATION

Health Care Provider's Name:	
Health Care Provider's Address:	
Telephone:	Fax:
Email:	
Type of Practice/Medical Specialty:	

Please check the box below that best describes your status:

- ☐ 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
- ☐ Other health care provider

Part B: MEDICAL STATUS

1. Please classify the current servicemember's or veteran's medical condition (check one box only):

☐ The person who needs care is a **current servicemember** of the Armed Forces whose medical condition is:

- ☐ **(VSI) Very Seriously Ill/Injured** – Illness/injury is of such severity that life is imminently endangered. Family members are requested at bedside immediately. Please note that this is an internal DOD casualty assistance designation used by DOD health care 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 health care 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 §825.113 of the FMLA. If such leave is requested, you will be required to complete an employer-provided form seeking the same information).

☐ The person who needs care is a **veteran** of the Armed Forces whose 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 U.S. Department of Veterans Affairs Service Related Disability Rating (VASRD) of 50% or higher, as 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 impaired 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 current servicemember or 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 started:

4. Probable duration of condition and/or need for care:

5. Is the current servicemember or veteran undergoing medical treatment, recuperation or therapy?
   ☐ Yes ☐ No

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

Part C: CURRENT SERVICEMEMBER'S OR VETERAN'S NEED FOR CARE BY FAMILY MEMBER
1. Will the current servicemember or 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: Begin Date: _____ End Date: _____
2. Will the current servicemember or veteran require periodic follow-up treatment appointments? ☐ Yes ☐ No If yes, estimate the treatment schedule:
3. Is there a medical necessity for the current servicemember or veteran to have periodic care for these follow-up treatment appointments? ☐ Yes ☐ No
4. Is there a medical necessity for the current servicemember or 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:

Part D: PROVIDER SIGNATURE	
Signature of Provider: _____	Date: _____

**Next of kin as defined in 29 CFR §825.127(b)(3) – "…the nearest blood relative, other than the covered servicemember's spouse, parent, son, or daughter, in the following order of priority: blood relatives who have been granted legal custody of the servicemember by court decree or statutory provisions, brothers and sisters, grandparents, aunts and uncles, and first cousins, unless the covered servicemember has specifically designated in writing another blood relative as his or her nearest blood relative for purposes of military caregiver leave under the FMLA…if there are multiple family members with the same level of relationship…all such family members shall be considered the covered servicemember's next of kin and may take FMLA leave to provide care…"* This definition applies to the next of kin of both current servicemembers and veterans.

Genetic Information Nondiscrimination Act of 2008 Notification

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 including, but not limited, to when the employee requests leave for a family member's health condition to (1) document appropriate use of sick leave; and (2) where "family medical history" is required to the extent necessary to make the medical certification complete and sufficient under the FMLA and WFMLA.

To comply with this law, we are asking that you not provide any genetic information when responding to this request for medical information unless it meets the family member exceptions noted above.

'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.