CUNY The City University of New York

FAMILY AND MEDICAL LEAVE ACT (FMLA)
CERTIFICATION FOR SERIOUS INJURY OR ILLNESS OF A CURRENT SERVICEMEMBER - MILITARY FAMILY LEAVE

SECTION I :

TO BE COMPLETED BY THE EMPLOYEE AND/OR THE CURRENT SERVICEMEMBER FOR WHOM THE EMPLOYEE IS REQUESTING LEAVE

This section must be completed first before submitting it to the Healthcare Provider.

INSTRUCTIONS TO EMPLOYEE OR CURRENT SERVICEMEMBER:

The FMLA permits CUNY 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 servicemember. Your response is required to obtain or retain the benefit of FMLA-protected leave. Failure to do so may result in denial of your FMLA request.

You have at least 15 calendar days to return this form to CUNY.

This form must be returned by _____

PART A: EMPLOYEE INFORMATION

Employer College/Unit _____ Address _____

City _____ State _____ Zip Code _____ Tel. _____ FAX _____

Name of Employee _____ Empl. ID _____ Department _____

CERTIFICATION OF FAMILY RELATIONSHIP

Name of current servicemember for whom employee is seeking leave _____

Relationship of employee to current servicemember *(Certification of Family Relationship Form or other legal documents attached)* _____

PART B: SERVICEMEMBER INFORMATION

Is the servicemember a current member of the Regular Armed Forces, the National Guard or Reserves? ☐ Yes ☐ No

If yes, please provide the servicemember's military branch, rank and unit currently assigned to: _____

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 members of the Armed Forces receiving medical care as outpatients (such as a medical hold or warrior transition unit)? ☐ Yes ☐ No

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

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

PART C: CARE TO BE PROVIDED TO THE SERVICEMEMBER

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

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SECTION II

FOR COMPLETION BY A UNITED STATES DEPARTMENT OF DEFENSE (DOD) HEALTH CARE PROVIDER OR A HEALTHCARE PROVIDER WHO IS EITHER : 1) A US DEPT. OF VETERANS AFFAIRS)(VA) HEALTHCARE PROVIDER; 2) A DOD TRICARE NETWORK AUTHORIZED PRIVATE HEALTHCARE PROVIDER; 3) A DOD NON-NETWORK TRICARE AUTHORIZED PRIVATE HEALTHCARE PROVIDER; 4) A HEALTHCARE PROVIDER AS DEFINED IN THE FMLA.
If you are unable to make certain of the military-related determinations contained below in Part B, you are permitted to rely upon determination from an authorized DOD representative (such as a DOD recovery care coordinator).

INSTRUCTIONS TO THE HEALTHCARE PROVIDER

The employee listed on Page 1 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.

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 his or her office, grade, rank, or rating.

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 healthcare 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 FLMLA coverage. Limit your responses to the servicemember's condition for which the employee is seeking leave. Do not provide information about genetic tests, or genetic services.

PLEASE PRINT CLEARLY OR TYPE. SIGN THE FORM ON THE LAST PAGE (PAGE 3)

PART A: HEALTHCARE PROVIDER INFORMATION

Health Care Provider's Name _____ Tel.: _____ FAX _____

Address _____

City _____ State _____ Zip Code _____ Country _____

Type of Practice / Medical Speciality

PART B: MEDICAL STATUS

The current servicemember's medical condition is classified as: *(check appropriate box)*

(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 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 that 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 take care for a covered family member with a "serious health condition" under 825.113 of the FMLA. If such leave is requested, you may be required to complete the Certification of Healthcare Provider for Family Member's Serious Health Condition Form.*

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Is the current servicemember 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

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

Is the current servicemember undergoing medical treatment, recuperation, or therapy for this condition? ☐ Yes ☐ No

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

PART C: SERVICEMEMBER'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 servicemember 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 servicemember who is receiving inpatient or home care.

Will the servicemember need care for a single continuous period of time, including any time for treatment and recovery? ☐ Yes ☐ No

If yes, estimate the beginning and end dates: From Date _____ To Date _____

Will the servicemember require periodic follow-up treatment appointments? ☐ Yes ☐ No

If yes, estimate the treatment schedule:

Is there a medical necessity for the servicemember to have periodic care for these follow-up treatment appointments? ☐ Yes ☐ No

Is there a medical necessity for the servicemember 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:

SIGNATURE OF HEALTHCARE PROVIDER

Print Name _____ Signature _____

License # _____ Date _____