Printed Name of Employee: _____

Accessibility @ TU
800 South Tucker Drive ▪ McClure Hall,
Room 104 ▪ Tulsa, Oklahoma 74104
ph: (918) 631-2334 / f: (918) 631-3459 ▪ E-mail:
access@utulsa.edu accessibility.utulsa.edu

**Certification of Health Care Provider for Current Servicemember's Serious Health Condition under FMLA (Family and Medical Leave Act) for Military Caregiver Leave**

Do not send completed form to the Department of Labor; Return to the ADA/504 Coordinator at TU.

OMB Control Number: 1235-0003 Expires: 8/31/2023

## Section 1: Employee

Please complete Section I before giving this to the servicemember's health care provider. The FMLA permits an employer to require that employees submit a timely, complete, and sufficient certification to support a request for FMLA leave to care for a covered servicemember with a serious health condition or injury. This certification is submitted by the servicemember's health care provider. Failure to provide a complete and sufficient certification may result in a denial of your FMLA request. **Please submit this form back to the TU ADA/504 Coordinator within 15 calendar days of receiving it.**

An employee may not be held liable for administrative delays in the issuance of military documents, despite the employee's diligent, good-faith effort to obtain such documents. In lieu of this form, TU will accept as sufficient certification invitational travel orders (ITOs) or invitational travel authorizations (ITAs) issued to any family members 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.

**Your Name**:_____
First Middle Last

**Title**: _____ **Department**: _____

**Phone**: _____ **Date Certification Requested**: _____

(1) **Name of the current servicemember for whom you will provide care/are requesting leave:**

_____
First Middle Last

(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 legal or biological relationship is necessary. Next of Kin is the servicemember's nearest blood relative, other than the spouse, parent, or child 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) siblings, (4) grandparents, (5) aunts and uncles, (6) first cousins.

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(3) **The servicemember (☐ is/☐ is not) a current servicemember of the Regular Armed Forces, including the National Guard or Reserves.**

(4) **If yes to the above, please provide the servicemember's military branch, rank, and unit currently assigned to**: _____

_____

(5) **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: _____**

(6) **The servicemember (☐ is/☐ is not)** on the Temporary Disability Retired List (TDRL).

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

☐ Assistance with basic medical, hygienic, nutritional, or safety needs ☐ Transportation

☐ Physical care ☐ Psychological comfort ☐ Other (please specify): _____

(8) **Give your best estimate of the amount of leave time needed to provide the care described:** _____

_____

(9) **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**: _____

*Now provide this form to the current servicemember's health care provider.*

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## Section II: Health Care Provider

Please provide your contact information, complete all relevant parts of this Section, and sign the form below. The employee listed in Section I has requested leave under the FMLA to care for a family member who is a current servicemember of the Regular Armed Forces, 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. The FMLA allows an employer to require that the employee submit a timely, complete, and sufficient medical certification to support a request for FMLA military caregiver leave to care for a current servicemember with a serious health condition. For FMLA purposes, a "serious health condition" 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 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 their serious injury or illness, the servicemember is not able to care for their 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 care. For more information about the definitions of a serious health condition under the FMLA, see the chart at the end of the form.

A complete and sufficient certification to support a request for FMLA military caregiver leave due to a current servicemember's serious health condition includes written documentation confirming that the servicemember's injury or illness was incurred in the line of duty on active duty or, if not, 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. Information about the FMLA may be found on the WHD website.

Provider's name: _____

Provider's business address: _____

Type of practice/Medical specialty: _____

Telephone: (_____) _____ Fax: (_____) _____

**Please attach a copy of your business card.**

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 A: Medical Information

Please provide appropriate medical information for the patient as requested below. Limit your responses to the current servicemember's 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. 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), genetic services, as defined in 29 C.F.R. § 1635.3(f), or genetic services, as defined in 29 CFR § 1635.3(e). If more room is needed to answer a question, please attach the rest of the answer.

(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 will last: _____

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

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

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

_____

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

☐ **(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 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 CFR § 825.113 of the FMLA. If such leave is requested, you may be required to complete a Certification Form seeking the same information.*

## 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 military caregiver leave coverage.

(6) Due to the condition, the servicemember will need care for a **continuous period of time,** including any time for treatment and recover. Provide your **best estimate** of the beginning date _____ *(mm/dd/yyyy)* and end date _____ *(mm/dd/yyyy)* for this period of time.

(7) 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)*

(8) 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 (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 is likely to last approximately _____ (☐ hours/ ☐ days) per episode.

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

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