**HEALTH CARE PROVIDER CERTIFICATION**

**FOR SERVICEMEMBER OR VETERAN**

**Return to Sedgwick**

**Email: ChevronMail@sedgwick.com | Fax: 855-800-5116 | PO Box 14648, Lexington, KY 40512 | Phone: 1-888-825-5247**

**Employee Name: <Employee Name>**

**Claim Number: <File Number>**

**Instructions for the Employee:**
The Family and Medical Leave Act (FMLA) provides that eligible employees may take FMLA leave to care for a covered servicemember with a serious illness or injury. The FMLA allows an employer to require an employee seeking FMLA leave for this purpose to submit a medical certification. 29 U.S.C. §§ 2613, 2614(c)(3). The employer must give the employee at least 15 calendar days to provide the certification. If the employee fails to provide complete and sufficient certification, his or her FMLA leave request may be denied. 29 C.F.R. § 825.313. Information about the FMLA may be found on the WHD website at www.dol.gov/agencies/whd/fmla.

Complete this section before giving this form to your family member or their health care provider. It is important that your family member’s health care provider answers the questions on this form related to the family member’s medical condition. If we do not receive the information requested, it may result in a denial of your request for leave under the Family and Medical Leave Act (FMLA), state/local and company leaves. We may not request any recertifications for FMLA leave to care for a covered servicemember.

We are required to provide you with at least 15 calendar days to return a complete and sufficient form. It is your responsibility to ensure that the certification is provided in a timely manner. However, you will not be held liable for administrative delays in the issuance of military documents, despite your diligent, good-faith efforts to obtain such documents. We will accept as sufficient certification invitational travel orders (ITOs) or invitational travel authorizations (ITAs) issued to any family member 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.

**PART A: EMPLOYEE INFORMATION**

Name of current Servicemember or veteran (for whom employee is requesting leave to care):

First Middle Last

Relationship of employee to current Servicemember or veteran requesting leave to care:

\_\_\_\_ Spouse \_\_\_\_ Father \_\_\_\_ Mother \_\_\_\_ Child \_\_\_\_ Domestic Partner \_\_\_\_ Next of Kin

Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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 or veteran 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 or veteran for whom the employee has assumed the obligations of a parent. No biological or legal relationship is necessary. “Next of kin” is the servicemember’s or veteran’s nearest blood relative, other than the spouse, parent, son, or daughter, in the following order of priority: (1) a blood relative as designated in writing by the servicemember or veteran for purposes of FMLA leave, (2) blood relatives granted legal custody of the servicemember or veteran, (3) brothers and sisters, (4) grandparents, (5) aunts and uncles, and (6) first cousins.

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**PART B: CURRENT SERVICEMEMBER INFORMATION**

Complete this section only if you are requesting leave to care for a current Servicemember; if you are requesting leave to care for a veteran, skip to Part C on the following page.

1. Is the current Servicemember a current member of the Regular Armed Forces, the National Guard or Reserves? \_\_\_\_ No \_\_\_\_ Yes

If yes, provide the current Servicemember’s military branch, rank, and unit currently assigned to:

Is the current 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 (such as a medical hold or warrior transition unit)? \_\_\_\_ No \_\_\_\_ Yes

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

1. Is the current Servicemember on the Temporary Disability Retired List (TDRL)? \_\_\_\_ No \_\_\_\_ Yes

**PART C: VETERAN INFORMATION**

Complete this section only if you are requesting leave to care for a veteran

1. Date of the veteran’s discharge:
2. Was the veteran dishonorably discharged or released from the Armed Forces \_\_\_\_ No \_\_\_\_ Yes
3. Provide the veteran’s military branch, rank and unit at the time of discharge:

1. Is the veteran receiving medical treatment, recuperation or therapy for an injury or illness? \_\_\_\_ No \_\_\_\_ Yes

**PART D: CARE TO BE PROVIDED TO THE SERVICEMEMBER OR VETERAN**

1. Describe the care to be provided to the Servicemember/veteran and an estimate of the leave needed to provide the care:

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**Instructions for the Health care Provider**

To be completed by one of the following:

1. A United States Department of Defense (“DOD”) health care provider
2. A United State Department of Veterans Affairs (“VA”) health care provider
3. A DOD TRICARE network authorized private health care provider
4. A DOD non-network TRICARE authorized private health care provider
5. A health care provider as defined in 29 CFR 825.125.

The employee noted at the top of this form has requested leave under the military caregiver leave provision of the FMLA to care for one of the following:

1. A family member who is a member of the Armed Forces 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 that may render the Servicemember medically unfit to perform the duties of his or her office, grade, rank, or rating.
2. A family member who is a veteran. For purposes of FMLA military caregiver leave, a serious injury or illness 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) and manifested itself before or after the Servicemember became a veteran, and is: **(i)** 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; or **(ii)** 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 percent or greater, and such VASRD rating is based, in whole or in part, on the condition precipitating the need for military caregiver leave; or **(iii)** 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; or **(iv)** an injury, including a psychological injury, on the basis of which the covered veteran has been enrolled in the Department of Veterans’ Affairs Program of Comprehensive Assistance for Family Caregivers.

 A complete and sufficient certification to support this request includes written documentation confirming that the servicemember’s/veteran’s injury or illness was incurred in the line of duty on active duty or existed before the beginning of the servicemember’s/veteran’s active duty and was aggravated by service in the line of duty on active duty, and that the servicemember/veteran is undergoing treatment, recuperation, or therapy for such injury or illness by a health care 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 FMLA military caregiver leave coverage. Limit your responses to the veteran’s condition for which the employee is seeking leave.

Please ensure that the section above has been completed before completing this section. Please be sure to sign the form on the last page and return this form to the employee requesting leave.

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**Part E: HEALTH CARE PROVIDER INFORMATION**

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. To comply with this law, we are asking that you not provide any genetic information when responding to this request for medical information. ‘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, information about the manifestation of a disease or disorder in an individual’s family members, the fact that an individual or an individual’s family member sought or received genetic services (including genetic testing, counseling, or education), or participated in clinical research  which includes such 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.

Notwithstanding the foregoing, family medical history may be provided when FMLA caregiver leave is requested to care for a family member, as long as the family medical history is limited to information needed to substantiate the serious health condition of the family member to be cared for.

Provider name:

Business address:

 Street City State Zip Code

Type of practice / Medical specialty:

Tax Id / NPI Number:

Telephone: ( ) Fax :( )

Please state whether you are either (check box):

\_\_\_\_ (1) a DOD health care provider;

\_\_\_\_ (2) a VA health care provider;

\_\_\_\_ (3) a DOD TRICARE network authorized private health care provider;

\_\_\_\_ (4) a DOD non-network TRICARE authorized private health care provider; or

\_\_\_\_ (5) a health care provider as defined in 29 CFR 825.125

 If you are unable to make certain of the military-related determinations contained below in Part F, you are permitted to rely upon determinations from an authorized DOD representative (such as a DOD recovery care coordinator).

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**PART F: MEDICAL STATUS**

Current Servicemember (only complete questions 1 and 2 if leave is being requested to care for a current Servicemember; if leave is being requested to care for a veteran, skip to questions 3 and 4 below)

1. Current Servicemember’s medical condition is classified as (check one of the appropriate boxes):

\_\_\_\_ **(VSI) Very Seriously Ill/Injured –** Illness/Injury is of such a severity that life is imminentlyendangered. Family members are requested at bedside immediately. (Please note 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** – 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 may be required to complete DOL FORM WH-380 or an employer-provided form seeking the same information.)

1. Was the condition for which the current Servicemember is being treated for a condition which was incurred or aggravated by service in the line of duty on active duty in the Armed Forces? \_\_\_\_ No \_\_\_\_ Yes
2. The Veteran’s medical condition is: (check one of the appropriate boxes)

\_\_\_\_ 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 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 § 825.113 of the FMLA. If such leave is requested, you may be required to complete DOL FORM WH-380 or an employer-provided form seeking the same information.)

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1. Is the 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? \_\_\_\_ No \_\_\_\_ Yes
2. Approximate date condition commenced:
3. Probable duration of condition and/or need for care:
4. Is the current servicemember/veteran undergoing medical treatment, recuperation, or therapy? \_\_\_\_ No \_\_\_\_Yes

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

**PART G: CURRENT SERVICEMEMBER’S OR VETERAN’S NEED FOR CARE BY FAMILY MEMBER**

“Need for care” encompasses both physical and psychological care. It includes situations where, for example, due to their serious injury or illness, the servicemember/veteran is unable to care for their own basic medical, hygienic, or nutritional needs or safety, or is unable to transport them self to the doctor. It also includes providing psychological comfort and reassurance which would be beneficial to the servicemember/veteran who is receiving inpatient or home care.

1. Will the current servicemember/veteran need care for a single continuous period of time, including any time for treatment and recovery? \_\_\_\_ No \_\_\_\_ Yes

If yes, estimate the beginning and ending dates for this period of time:

\_\_\_\_\_\_/\_\_\_\_\_ /\_\_\_\_\_\_\_ through \_\_\_\_\_\_/\_\_\_\_\_ /\_\_\_\_\_\_\_

1. Will the current servicemember/veteran require periodic follow-up treatment appointments? \_\_\_\_ No \_\_\_\_ Yes

If yes, estimate the treatment schedule:

1. Is there a medical necessity for the current servicemember/veteran to have periodic care for these follow-up treatment appointments? \_\_\_\_ No \_\_\_\_ Yes
2. Is there a medical necessity for the current servicemember/veteran to have periodic care for other than scheduled follow-up treatment appointments (e.g., episodic flare-ups of medical condition)? \_\_\_\_ No \_\_\_\_ Yes

If yes, estimate the frequency and duration of the periodic care:

Frequency: \_\_\_\_\_\_\_\_\_episode(s) every \_\_\_\_\_\_\_\_ week(s) or \_\_\_\_\_\_\_\_ month(s)

Duration: \_\_\_\_\_\_\_\_hour(s) or \_\_\_\_\_\_\_\_ day(s) per episode

Signature of Health care Provider Date