SALT LAKE COUNTY

Human Resources

Serious Injury or Illness of Covered Service Member

Certification of Health Care Provider

(Family and Medical Leave Act of 1993 as Amended)

To be completed by **Agency**

This form is confidential. Agency must maintain documents relating to medical certifications, recertifications or medical history of employees created for FMLA as confidential medical records in a file separate from the personnel file.

Agency contact person and phone/email:

SECTION I: To be completed by **Employee** and/or **Covered Service Member** for whom the employee is requesting leave.

Employee must submit this form to the Agency contact person listed above within 15 calendar days.

PART A: EMPLOYEE INFORMATION

Name of Employee Requesting Leave:

Last Name First Name Middle Name/Initial

Name of Covered Service Member

Last Name First Name Middle Name/Initial

Relationship of Employee to Covered Service Member: ☐ Spouse ☐ Parent ☐ Son ☐ Daughter ☐ Next of Kin

PART B: COVERED SERVICE MEMBER INFORMATION

1. Is the Covered Service Member a current member of the Regular Armed Forces, the National Guard or Reserves? ☐ Yes ☐ No

If yes, please provide the Covered Service Member's currently assigned military branch, rank and unit:

Is the covered 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 o f members receiving medical care as outpatients (such as a medical hold or warrior transition unit?)

☐ Yes ☐ No

2. Is the Covered Service Member on the Temporary Disability Retired List (TDRL)?

☐ Yes ☐ No

PART C: CARE TO BE PROVIDED

3. Describe the care to be provided to the Covered Service Member and an estimate of the leave needed to provide the care:

SECTION II: To Be Completed by Health Care Provider

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 or 3) a DOD non-network TRICARE authorized private health care provider.

If you are unable to make certain of the military-related determinations contained below in Part B, you are permitted to rely upon determinations from an authorized DOD representative (such as a DOD Recovery Care Coordinator). Please ensure that Section I above has been completed before completing this section. Please be sure to sign the form on the last page.

PART A: HEALTH CARE PROVIDER INFORMATION

Health Care Providers Name and Business Address:

Type of Practice/Medical Specialty:

Please check whether you are either:

☐ 1) a DOD health care provider,

☐ 2) a VA health care provider,

☐ 3) a DOD TRICARE network authorized private health care provider, or

☐ 4) a DOD non-network TRICARE authorized health care provider:

Telephone:

Fax:

Email:

PART B: MEDICAL STATUS

1. Covered Service Member's medical condition is classified as (check one):

☐ (VSI) Very 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.)

☐ (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 service member medially 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 are required to complete the Certification of Health Care Provider – Family's Serious Health Condition form.

2. Was the condition for which the covered service member is being treated incurred in the line of duty on active duty in the armed forces?

☐ Yes ☐ No

3. Approximate date condition commenced: _____

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

_____

5. Is the Covered Service Member undergoing medical treatment, recuperation, or therapy?

☐ Yes ☐ No

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

_____

PART C: COVERED SERVICE MEMBER'S NEED FOR CARE BY FAMILY MEMBER

1. Will the covered service member 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:

_____

2. Will the Covered Service Member require periodic follow-up treatment appointments?

☐ Yes ☐ No

If yes, estimate the treatment schedule:

_____

3. Is there a medical necessity for the covered service member to have periodic care for these follow-up treatment appointments?

☐ Yes ☐ No

4. Is there a medical necessity for the Covered Service Member 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 (e.g. 1 episode every 3 months lasting 1-2 days).

Frequency: _____ times per _____ week(s) _____ month(s)

Duration: _____ hours or _____ day(s) per episode

Here and elsewhere on this form, the information sought relates only to the condition for which the employee is taking FMLA leave.

_____

Signature of Health Care Provider Date