

**University of Missouri**  
**Certification for Serious Injury or Illness of Covered Servicemember - -**  
**for Military Family Leave**  
**(Family and Medical Leave Act)**

**SECTION I: For Completion by the EMPLOYEE and/or the COVERED SERVICEMEMBER for whom the Employee Is Requesting Leave:** Please complete Section I before having Section 11 completed. The FMLA permits an employer 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 covered servicemember. If requested by the employer, your response is required to obtain or retain the benefit of FMLA-protected leave. 29 U.S.C. §§ 2613, 2614(c)(3). Failure to do so may result in a denial of an employee's FMLA request. 29 C.F.R. § 825.3 1 0(f). The employer must give an employee at least 15 calendar days to return this form to the employer.

**SECTION II: 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:** The employee listed on Page 2 has requested leave under the FMLA to care for a family member who is a 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 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 covered servicemember's serious injury or illness includes written documentation confirming that the covered 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 covered servicemember is undergoing treatment 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 coverage. Limit your responses to the condition for which the employee is seeking leave.

**SECTION I: For Completion by the EMPLOYEE and/or the COVERED SERVICEMEMBER for whom the Employee Is Requesting Leave: (This section must be completed first before any of the below sections can be completed by a health care provider.)**

**Part A: Employee Information**

Employer Name (this is the employer of the employee requesting leave to care for covered servicemember)	
Employer Address	
Name of Employee Requesting Leave to Care for Covered Servicemember (First, Middle, Last)	Name of Covered Servicemember for Whom Employee is Requesting Leave to Care (First, Middle, Last)
Relationship of Employee to Covered Servicemember requesting Leave to Care	
<input type="checkbox"/> Spouse <input type="checkbox"/> Parent <input type="checkbox"/> Son <input type="checkbox"/> Daughter <input type="checkbox"/> Next of Kin	

## Part B: COVERED SERVICEMEMBER INFORMATION

1. Is the covered servicemember a current member of the Regular Armed Forces, National Guard or Reserves?  Yes  No  
If yes, please provide the covered servicemember's military branch, rank and unit currently assigned to:
- Is the covered 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, please provide the name of the medical treatment facility or unit:
2. Is the covered servicemember on the Temporary Disability Retired List (TDRL)?  Yes  No

## Part C: CARE TO BE PROVIDED TO THE COVERED SERVICEMEMBER

Describe the Care to Be Provided to the Covered Servicemember and an Estimate of the Duration of the Leave Needed to Provide the Care:

**SECTION II: 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 13, 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 Provider's Name		Health Care Provider's Business Address	
Type of Practice/Medical Specialty			
Please state whether you are either:			
<input type="checkbox"/> A DOD health care provider		<input type="checkbox"/> A VA health care provider	
<input type="checkbox"/> A DOD TRICARE network authorized private health care provider		<input type="checkbox"/> A DOD non-network TRICARE authorized private health care provider	
Telephone (       )	Fax (       )	Email	

## Part B: MEDICAL STATUS

1. Covered Servicemember's medical condition is classified as (Check One of the Appropriate Boxes):
- (VSI) Very Seriously III/Injured - Illness/Injury is of such a 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 III/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 III/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 may be required to complete a different certification.)

2. Was the condition for which the Covered Service member is being treated incurred in line of duty on active duty in the armed forces?  Yes  No

3. Approximate Date Condition Commenced Probable Duration of Condition and/or need for care

4. Is the covered servicemember undergoing medical treatment, recuperation, or therapy?  Yes  No  
 If yes, please describe medical treatment, recuperation or therapy:

**Part C: COVERED SERVICEMEMBER'S NEED FOR CARE BY FAMILY MEMBER**

1. Will the covered 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 ending dates for this period of time:

2. Will the covered servicemember require periodic follow-up treatment appointments?  Yes  No  
 If yes, estimate the treatment schedule:

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

4. Is there a medical necessity for the covered 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:

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 employees or their family members. In order 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, 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.

\_\_\_\_\_  
 Signature of Health Care Provider

\_\_\_\_\_  
 Date