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

U.S. Department of Labor

Employment Standards Administration Wage and Hour Division



OMB Control Number: 1215-0181 Expires: 12/31/2011

Notice to the EMPLOYER INSTRUCTIONS to the EMPLOYER: The Family and Medical Leave Act (FMLA) provides that an employer may require an employee seeking FMLA leave due to a serious injury or illness of a covered servicemember to submit a certification providing sufficient facts to support the request for leave. Your response is voluntary. While you are not required to use this form, you may not ask the employee to provide more information than allowed under the FMLA regulations, 29 C.F.R. § 825.310. Employers must generally maintain records and documents relating to medical certifications, recertifications, or medical histories of employees or employees' family members, created for FMLA purposes as confidential medical records in separate files/records from the usual personnel files and in accordance with 29 C.F.R. § 1630.14(c)(1), if the Americans with Disabilities Act applies.

SECTION I: For Completion by the EMPLOYEE and/or the COVERED SERVICEMEMBER for whom the Employee Is Requesting Leave INSTRUCTIONS to the EMPLOYEE or COVERED SERVICEMEMBER: Please complete Section I before having Section II 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. § 825.310(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 INSTRUCTIONS to the 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 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.

Page 1 CONTINUED ON NEXT PAGE Form WH-385 January 2009

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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

| | ne and Address of Employ icemember): | ver (this is the employer of | the employee requesting le | eave to care for covered | |
|-------|---|---|-----------------------------|--------------------------------|--|
| Nam | ne of Employee Requestin | g Leave to Care for Covere | ed Servicemember: | | |
| First | | Middle | Last | | |
| Nam | ne of Covered Servicemer | nber (for whom employee | s requesting leave to care) |): | |
| | First | Middle | Last | | |
| | | Covered Servicemember R Daughter Dext of R | | | |
| Part | B: COVERED SERVIC | EMEMBER INFORMATI | ON | | |
| (1) | Is the Covered Servicemember a Current Member of the Regular Armed Forces, the National Guard or Reserves?YesNo | | | | |
| | 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 (such as a medical hold or warrior transition unit)?YesNo If yes, please provide the name of the medical treatment facility or unit: | | | | |
| (2) | Is the Covered Servicer | nember on the Temporary | Disability Retired List (TD | ORL)?YesNo | |
| Part | C: CARE TO BE PROV | IDED TO THE COVEREI |) SERVICEMEMBER | | |
| | cribe the Care to Be Provi Care: | ded to the Covered Service | member and an Estimate of | of the Leave Needed to Provide | |
| | | | | | |

Page 2 CONTINUED ON NEXT PAGE Form WH-385 January 2009

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 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 Provider's Name and Business Address: | | | |
|--|--|--|--|
| Type of Practice/Medical Specialty: | | | |
| Please state 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 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 Ill/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 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 § 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.) | | | |
| (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: | | | |
| (4) Probable duration of condition and/or need for care: | | | |
| (5) Is the covered servicemember undergoing medical treatment, recuperation, or therapy?YesNo. 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?YesNo |
| (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)?YesNo If yes, please estimate the frequency and duration of the periodic care: |
| | |
| Sig | gnature of Health Care Provider: Date: |

PAPERWORK REDUCTION ACT NOTICE AND PUBLIC BURDEN STATEMENT

If submitted, it is mandatory for employers to retain a copy of this disclosure in their records for three years, in accordance with 29 U.S.C. § 2616; 29 C.F.R. § 825.500. Persons are not required to respond to this collection of information unless it displays a currently valid OMB control number. The Department of Labor estimates that it will take an average of 20 minutes for respondents to complete this collection of information, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. If you have any comments regarding this burden estimate or any other aspect of this collection information, including suggestions for reducing this burden, send them to the Administrator, Wage and Hour Division, U.S. Department of Labor, Room S-3502, 200 Constitution AV, NW, Washington, DC 20210. **DO NOT SEND THE COMPLETED FORM TO THE WAGE AND HOUR DIVISION; RETURN IT TO THE PATIENT.**

Page 4 Form WH-385 January 2009