THE UNIVERSITY OF ARIZONA
Human Resources

CERTIFICATION FOR SERIOUS INJURY OR ILLNESS OF A VETERAN FOR MILITARY CAREGIVER LEAVE
(Family and Medical Leave Act)

Notice to the EMPLOYER

The Family and Medical Leave Act (FMLA) provides that an employer may require an employee seeking military caregiver leave under the FMLA leave due to a serious injury or illness of a covered veteran to submit a certification providing sufficient facts to support the request for leave. You may not ask the employee to provide more information than allowed under the FMLA regulations. 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.

Employer name: The University of Arizona Department #/Name: _____

Supervisor/Designated Leave Coordinator: _____

SECTION I: For Completion by the EMPLOYEE and/or the VETERAN for whom the employee is requesting leave

INSTRUCTIONS to the EMPLOYEE or **CURRENT 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 servicemember. If requested by the employer, your response is required to obtain or retain the benefit of FMLA-protected leave. Failure to do so may result in a denial of an employee's FMLA request. The employer must give an employee at least 15 calendar days to return this form to the employer.

(This section must be completed before Section II can be completed by a health care provider.)

Part A: EMPLOYEE INFORMATION

Name of employer (this is the employer of the employee requesting leave to care for a veteran): The University of Arizona

Name of employee requesting leave to care for a veteran: _____ Empl ID: _____

Employee's title: _____ Regular work schedule: _____

Department #/Name: _____ Supervisor/Designated Leave Coordinator: _____

Name of veteran (for whom employee is requesting leave): _____

Relationship of employee to veteran: ☐ Spouse ☐ Parent ☐ Child

Next of Kin (please specify relationship): _____

Part B: VETERAN INFORMATION

1. Date of the veteran's discharge:

   _____

2. Was the veteran **dishonorably** discharged or released from the Armed Forces (including the National Guard or Reserves)?
   Yes ☐ No ☐
3. Please provide the veteran's military branch, rank and unit at the time of discharge:

   _____
4. Is the veteran receiving medical treatment, recuperation, or therapy for an injury or illness?
   Yes ☐ No ☐

Part C: CARE TO BE PROVIDED TO THE VETERAN

Describe the care to be provided to the veteran and an estimate of the leave needed to provide the care:

_____

_____

SECTION II: For completion by: (1) a United States Department of Defense ("DOD") health care provider; (2) a United States 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; or (5) a health care provider as defined in 29 CFR 825.125.

INSTRUCTIONS to the HEALTH CARE PROVIDER: The employee named in Section I has requested leave under the military caregiver leave provision of the FMLA to care for 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 a request for FMLA military caregiver leave due to a covered veteran's serious injury or illness includes written documentation confirming that the veteran's injury or illness was incurred in the line of duty on active duty or existed before the beginning of the veteran's active duty and was aggravated by service in the line of duty on active duty, and that the 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 Section I 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 (See Section I, Part A above**). DO NOT SEND THE COMPLETED FORM TO THE WAGE AND HOUR DIVISION.)**

Part A: HEALTH CARE PROVIDER INFORMATION

Health Care Provider's Name and Business Address:

_____

Telephone: _____ _____ Fax: ____ _____ Email: _____

Type of Practice/Medical Specialty: _____

Please indicate if you are:

☐a DOD health care provider

☐a VA health care provider

☐a DOD TRICARE network authorized private health care provider

☐a DOD non-network TRICARE authorized private health care provider

☐other health care provider

Part B: MEDICAL STATUS

(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 a 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.)

Note: If you are unable to make certain of the military-related determinations contained in Part B, you are permitted to rely upon determinations from an authorized DOD representative (such as, DOD Recovery Care Coordinator) or an authorized VA representative.

1. The Veteran's medical condition is:
   - ☐ 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.
2. 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? Yes ☐ No ☐
3. Approximate date condition commenced: _____
4. Probable duration of condition and/or need for care: _____
5. Is the veteran undergoing medical treatment, recuperation, or therapy for this condition? Yes ☐ No ☐

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

   _____

PART C: 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 his or her serious injury or illness, the veteran is unable to care for his or her own basic medical, hygienic, or nutritional needs or safety, or is unable to transport him or herself to the doctor. It also includes providing psychological comfort and reassurance which would be beneficial to the veteran who is receiving inpatient or home care.

1. Will the veteran 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 veteran require periodic follow-up treatment appointments? Yes ☐ No ☐

   If yes, estimate the treatment schedule: _____
3. Is there a medical necessity for the veteran to have periodic care for these follow-up treatment appointments?
   Yes ☐ No ☐
4. Is there a medical necessity for the veteran 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:

   _____

   _____

Date: _____ **Signature of Health Care Provider:** _____

Printed Name of Health Care Provider: _____ **Type of Practice:** _____

Address: _____

_____

FORM ROUTING

Physician: Return completed form to the Employee/Patient as identified in Section II

Patient: Return completed form to University Employee

Employee: Return completed form to Supervisor/Designated Leave Coordinator

Supervisor/Designated Leave Coordinator: Maintain form in confidential department file; copy to Human Resources - Benefits

ADAPTED FROM DEPARTMENT OF LABOR FORM WH-385-V, DOL REVISED MAY 2015, OMB CONTROL NUMBER 1235-0003, EXPIRES 5/31/2018