FMLA CERTIFICATION FOR SERIOUS INJURY OR ILLNESS
OF COVERED SERVICEMEMBER

SECTION I: For Completion by the Employee and/or 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

Address, Telephone Number, and Fax Number of Campus Human Resources Department (this is the campus of the employee requesting leave to care for a Covered Servicemember):
____________________________________________________________________________________

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:
_____ Spouse*  _____ Parent  _____ Son  _____ Daughter  _____ Next of Kin

PART B: Covered Servicemember Information

1. Is the Covered Servicemember a Current Member of the Regular Armed Forces, the National Guard or Reserves?
   _____ Yes  _____ No

   If yes, please provide the Covered Servicemember’s military branch, rank and unit:
   __________________________________________________________________________________

   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:
   __________________________________________________________________________________
Is the Covered Servicemember a veteran who was a member of the Armed Forces, the National Guard, or Reserves at any time during the five years preceding the date of the Covered Servicemember’s medical treatment, recuperation, or therapy for the condition for which you are seeking leave?

____ Yes  ____ No

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 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: (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.

PART A: Health Care Provider Information

Health Care Provider’s Name and Business Address (please print):

_____________________________________________________________________________________

Type of Practice / Medical Specialty: _________________________________________________________

State whether you are (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:

____ Very Seriously Ill / Injured (VSI) – Illness/Injury is of such 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 Health Care Providers).

____ Seriously Ill / Injured (SI) – 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 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 will be required to complete the Purdue University FMLA Medical Certification Form).

2. Was the condition for which the Covered Servicemember is being treated incurred in line of duty on active duty in the armed forces, or was it a pre-existing condition aggravated by service in the line of duty on active duty in the Armed Forces? _____ Incurred in line of duty _____ Pre-existing condition

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?  
   _____ 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:

   ________________________________________________________________

   ________________________________________________________________

Signature of Health Care Provider:

______________________________________________________________________________

Date