PURDUE UNIVERSITY

Revised 1/2017

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 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 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