

**SECTION 1: TO BE COMPLETED BY EMPLOYEE**

**INSTRUCTIONS to the EMPLOYEE:** Please complete Section 1 before having Section 2 completed. The FMLA permits an employer to require that you submit a timely, complete, and sufficient medical certification to support a request for an absence that may qualify as FMLA leave (Military Caregiver Absence) due to a serious injury or illness of a veteran. Your response is required to obtain or retain the benefit of FMLA and Military Caregiver Absence protections. Failure to provide a complete and sufficient medical certification may result in a denial of your FMLA and Military Caregiver Absence request. Section 2 of this form must be completed by the treating health care provider; it is inappropriate for it to be completed by anyone other than that provider. Note: If this is a request for leave for yourself or a family member with a serious health condition, you cannot use this form. Please obtain either: *Employee Serious Health Condition Certification* OR *Family Member Serious Health Condition Certification* from your human resources office.

Employee Name	Personnel Number
Agency	Work Location

**For Absences for Veterans, state the following:**

Family Member / Patient Name	Relationship to Employee (spouse, parent, son, daughter, service member next of kin)	
Was the veteran <b>dishonorably</b> discharged or released from the Armed Forces (including the National Guard or Reserves)?		
<input type="checkbox"/> Yes <input type="checkbox"/> No	Date of Discharge	
Was the individual a member of a regular or reserve component of the Armed Forces?		
<input type="checkbox"/> Yes <input type="checkbox"/> No		
Military Branch	Rank	Unit at time of discharge

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

Describe the care you will provide to the covered servicemember.

Estimate the amount of leave you will need to provide this care; include a schedule, if possible for intermittent absences.

**SECTION 2: TO BE COMPLETED BY HEALTH CARE PROVIDER:**

**INSTRUCTIONS to the HEALTH CARE PROVIDER:** The health care provider must be a United States Department of Defense Health Care Provider, a Health Care Provider who is either a US Department of Veterans Affairs health care provider, a Department of Defense Tricare network authorized private health care provider, a Department of Defense non-network Tricare authorized private health care provider or a health care provider as defined in the FMLA. The employee listed above has requested leave under the FMLA to care for a family member who is covered veteran undergoing medical treatment, recuperation, or therapy. For purposes of FMLA leave, a serious injury or illness is one that was incurred in the line of duty on active duty or existed before the beginning of the member's active duty and was aggravated by service in the line of duty on active duty and that manifested itself before or after the member became a veteran..

A complete and sufficient certification to support a request for FMLA leave due to a veteran's serious injury or illness includes written documentation confirming that the veteran's injury or illness was incurred or aggravated in the line of duty on active duty and that the veteran 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 on 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.

If you are unable to make certain of the military-related determinations contained below, you are permitted to rely upon determinations from an authorized Department of Defense representative (such as a recovery care coordinator). Please ensure the Section 1 above has been completed before completing this section. Please be sure to sign the form on the last page.

**Medical Status:**

Veteran's medical condition is classified as:

- A continuation of a serious injury or illness that was incurred or aggravated when the 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 veteran has received a U.S. Dept. of Veterans Affairs Service-Related Disability Rating (VASRD) of 50% or higher, and the VASRD rating is based on the condition precipitating the need for military caregiver leave.
- A physical or mental condition that substantially impairs the 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 veteran is enrolled in the Dept. of Veterans Affairs Program of Comprehensive Assistance for Family Caregivers.
- 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." If such leave is requested, you are required to complete the *Family Member Serious Health Condition Certification* form.)

1. Was the condition for which the veteran is being treated incurred or aggravated in line of duty on active duty in the armed forces?

- Yes  No

2. What is the approximate date the condition commenced?

3. What is the probable duration of the condition/incapacity and/or need for care?

4. Is the veteran undergoing medical treatment, recuperation, or therapy for this condition?

- Yes  No

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

**Servicemember's Need for Care by Family Member:**

5. Will the veteran need care for a single continuous period of time, including any time for treatment and recover?

- Yes  No

If yes, estimate the beginning and ending dates for this period of time.

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

If yes, estimate the treatment schedule.

7. Is there a medical necessity for the veteran to have periodic care for these follow-up treatment appointments?

- Yes  No

8. Is there a medical necessity for the veteran to have periodic care for other than scheduled follow-up treatment appointments (example: episodic flare-ups of medical condition)?  Yes  No

If yes, please estimate the frequency and duration of the periodic care.

Employee Name \_\_\_\_\_

Personnel Number \_\_\_\_\_

<b>By providing my original signature, the undersigned health care provider certifies that the information is true and accurate.</b>	
Printed Name of Health Care Provider	Type of Practice/Medical Specialty
Address	Telephone Number
Name and Title of Person Completing the form, if not the Health Care Provider	Fax Number
Please state whether you are a: <input type="checkbox"/> DOD health care provider <input type="checkbox"/> DOD TRICARE network authorized private health care provider <input type="checkbox"/> DOD non-network TRICARE authorized private health care provider <input type="checkbox"/> VA health care provider <input type="checkbox"/> Other health care provider	
Signature of Health Care Provider	Date

*Please return this form to the employee or to:*

**FMLA Specialist**  
**HR Service Center - FMLA**  
**PO Box 824**  
**Harrisburg, PA 17108-0824**

**Phone: 717.346.4667    Fax: 717.425.5389    Email: RA-SPFabsence@pa.gov**