COLORADO
Division of Human Resources
Department of Personnel & Administration

WHD
U.S. Wage and Hour Division

State of Colorado Certification for Serious Injury or Illness of a Current Service Member – for Military Family Leave (Family and Medical Leave Act)

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 current service member 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 CFR 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 CFR 1630.14(c)(1), if the Americans with Disabilities Act applies, and in accordance with 29 CFR 1635.9, if the Genetic Information Nondiscrimination Act applies.

SECTION I: For Completion by the EMPLOYEE and/or the CURRENT SERVICE MEMBER for whom the Employee Is Requesting Leave

INSTRUCTIONS to the EMPLOYEE or CURRENT SERVICE MEMBER: 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 service member. 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 CFR 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; (3) a DOD non-network TRICARE authorized private health care provider; or (4) a health care provider as defined in 29 CFR 825.125

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 current 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 in the Armed Forces or that existed before the beginning of the member's active duty and was aggravated by service in the line of duty on active duty in the Armed Forces that may render the service member 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 current service member's serious injury or illness includes written documentation confirming that the service member's injury or illness was incurred in the line of duty on active duty or if not, that the current service member's injury or illness existed before the beginning of the service member's active duty and was aggravated by service in the line of duty on active duty in the Armed Forces, and that the current service member 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 service member's condition for which the employee is seeking leave. Do not provide information about genetic tests, as defined in 29 CFR 1635.3(f), or genetic services, as defined in 29 CFR 1635.3(e).

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SECTION I: For Completion by the EMPLOYEE and/or the CURRENT SERVICE MEMBER 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

Name and Address of Employer (this is the employer of the employee requesting leave to care for the current service member):

_____

Name of Employee Requesting Leave to Care for the Current Service member:

_____
First Middle Last

Name of the Current Service member (for whom employee is requesting leave to care):

_____
First Middle Last

Relationship of Employee to the Current Service member:

Spouse ☐ Parent ☐ Son ☐ Daughter ☐ Next of Kin ☐

PART B: SERVICE MEMBER INFORMATION

(1) Is the Service member a Current Member of the Regular Armed Forces, the National Guard, or Reserves?

Yes ☐ No ☐

If yes, please provide the service member's military branch, rank, and unit currently assigned to:

_____

Is the service member 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)? Yes ☐ No ☐

If yes, please provide the name of the medical treatment facility or unit:

_____

(2) Is the Service member on the Temporary Disability Retired List (TDRL)? Yes ☐ No ☐

PART C: CARE TO BE PROVIDED TO THE SERVICE MEMBER

Describe the Care to Be Provided to the Current Service member and an Estimate of the Leave Needed to Provide the Care:

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(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; (4) a DOD non-network TRICARE authorized private health care provider, or (5) a health care provider as defined in 29 CFR 825.125:

_____

Telephone: ( )_____ Fax: ( )_____ E-mail: _____

PART B: MEDICAL STATUS

(1) The current Service member'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 service member 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-F or an employer-provided form seeking the same information.)

(2) Is the current service member 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 ____

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(3) Approximate date condition commenced:
_____

(4) Probable duration of condition and/or need for care: _____

(5) Is the service member undergoing medical treatment, recuperation, or therapy for this condition?
Yes ____ No ____

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

_____

_____

_____

PART C: SERVICE MEMBER'S NEED FOR CARE BY FAMILY MEMBER

(1) Will the service member 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 service member require periodic follow-up treatment appointments? Yes ____ No ____

If yes, estimate the treatment schedule: _____

(3) Is there a medical necessity for the service member to have periodic care for these follow-up treatment appointments? Yes ____ No ____

(4) Is there a medical necessity for the service member 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:_____

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 CFR 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 Ave., NW, Washington, DC 20210. **DO NOT SEND THE COMPLETED FORM TO THE WAGE AND HOUR DIVISION; RETURN IT TO THE PATIENT.**