Print Form

State of Colorado Certification for Serious Injury or Illness of Covered Servicemember for Military Family Leave

(Family and Medical Leave Act)

Instructions to Department/Institution: This completed form is to be placed in a separate, confidential medical file with limited access.

Pursuant to the Genetic Information Nondiscrimination Act (GINA)'s "safe harbor" provision in 29 CFR § 1635.8(b)(1)(i) and 29 CFR § 1635.8(b)(3) (providing for an exception for FMLA requests regarding the medical condition of a family member), the GINA disclosure language must be included with requests under the FMLA concerning a spouse, parent, or child's medical condition.

Instructions to Employee: Please complete Section I of the form prior to providing to the Department of Defense Health Care Provider. If this document is returned to your employing agency incomplete, or contains vague/ambiguous responses, this certificate will be returned to you for correction. Failure to provide a complete and sufficient certificate within 15 calendar days may result in denial of paid leave and the possible delay or denial of any applicable family/medical leave. Knowingly providing false information directly, or through another party, may result in corrective and/or disciplinary action.

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 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 that may render the servicemember 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 covered servicemember's serious injury or illness includes written documentation confirming that the covered servicemember's injury or illness was incurred in the line of duty on active duty and that the covered servicemember is undergoing treatment for such injury or illness by a health care provider as listed in Section II. 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 condition for which the employee is seeking leave.

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 this 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. <u>However, please be advised that GINA Title II does allow you to provide information about the medical condition of an employee's spouse, parent or child to certify the need for leave under the Family and Medical Leave Act (FMLA).</u>

SECTION I: For Completion by the EMPLOYEE and/or the 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
Name and address of employer (this is the employer of the employee requesting leave to care for 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 (circle one: granted legal custody by court decree, brother or sister, grandparent, aunt or uncle, first cousin)

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 currently assigned to:

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 (such as a medical hold or warrior transition unit)? ☐Yes ☐No

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

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(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 either: (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.) 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; 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 (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 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" regular FMLA. If such leave is requested, you may be required to complete a medical certification form for a family member. Contact your HR office for further information.)

(2) Was the condition for which the covered servicemember is being treated incurred in 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 covered servicemember undergoing medical treatment, recuperation, or therapy? ☐ Yes ☐ No.
If yes, please describe medical treatment, recuperation, or therapy: _____

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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:

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(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, estimate the frequency and duration of the periodic care:

_____ _____

Signature of Health Care Provider Date

Print Name: _____