



**CERTIFICATION FOR SERIOUS INJURY OR ILLNESS OF  
A CURRENT SERVICEMEMBER - FOR MILITARY FAMILY LEAVE  
(Family and Medical Leave Act)**

**NOTICE TO THE EMPLOYER**

**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 servicemember to submit a certification providing sufficient facts to support the request for leave. You may not ask the employee to provide more information than allowed under the FMLA regulations. 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.

Employer name: The University of Arizona Department #/Name: \_\_\_\_\_

Supervisor/Designated Leave Coordinator: \_\_\_\_\_

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

**INSTRUCTIONS to the EMPLOYEE or CURRENT SERVICEMEMBER:** 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 servicemember. If requested by the employer, your response is required to obtain or retain the benefit of FMLA-protected leave. Failure to do so may result in a denial of an employee’s FMLA request. 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 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 current servicemember’s serious injury or illness includes written documentation confirming that the servicemember’s injury or illness was incurred in the line of duty on active duty or if not, that the current servicemember’s injury or illness existed before the beginning of the servicemember’s active duty and was aggravated by service in the line of duty on active duty in the Armed Forces, and that the current servicemember 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 servicemember’s condition for which the employee is seeking leave.

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

Employer name: The University of Arizona Department #/Name: \_\_\_\_\_

Supervisor/Designated Leave Coordinator: \_\_\_\_\_

Name of Employee Requesting Leave to Care for the Current Servicemember:

\_\_\_\_\_ First Middle Last

Empl ID: \_\_\_\_\_

Employee's title: \_\_\_\_\_ Regular work schedule: \_\_\_\_\_

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

\_\_\_\_\_ First Middle Last

Relationship of Employee to the Current Servicemember:  Spouse  Parent  Child  Next of Kin

**Part B: SERVICEMEMBER INFORMATION**

1. Is the Servicemember a Current Member of the Regular Armed Forces, the National Guard or Reserves?

Yes  No

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

\_\_\_\_\_

Is the 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 the medical treatment facility or unit:

\_\_\_\_\_

2. Is the Servicemember on the Temporary Disability Retired List (TDRL)?

Yes  No

**Part C: CARE TO BE PROVIDED TO THE SERVICEMEMBER**

Describe the Care to Be Provided to the Current 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; (3) a DOD non-network TRICARE authorized private health care provider; or (4) a health care provider as defined in 29 CFR 825.125.**

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: HEALTHCARE 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:

Email:

**Part B: MEDICAL STATUS**

*(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 a 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.)*

1. The current 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" 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 Servicemember 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

3. Approximate date condition commenced: \_\_\_\_\_

4. Probable duration of condition and/or need for care: \_\_\_\_\_

5. Is the servicemember undergoing medical treatment, recuperation, or therapy for this condition? Yes  No

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

\_\_\_\_\_

**PART C: SERVICEMEMBER'S NEED FOR CARE BY FAMILY MEMBER**

1. Will the 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 servicemember require periodic follow-up treatment appointments? Yes  No

If yes, estimate the treatment schedule: \_\_\_\_\_

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

Yes  No

4. Is there a medical necessity for the 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: \_\_\_\_\_

Printed Name of Health Care Provider: \_\_\_\_\_

**Form Routing**

**Physician:** Return completed form to the Employee/Patient as identified in Section I

**Patient:** Return completed form to University Employee

**Employee:** Return completed form to Supervisor/Designated Leave Coordinator

**Supervisor/Designated Leave Coordinator:** Maintain form in confidential department file; copy to Human Resources - Benefits

ADAPTED FROM DEPARTMENT OF LABOR FORM WH-385, DOL REVISED MAY 2015, OMB CONTROL NUMBER 1235-0003, EXPIRES 5/31/2018