SECTION I: For completion by the EMPLOYEE

This section must be completed first before any of the below sections can be completed by a health care provider.

INSTRUCTIONS to the EMPLOYEE:

Please complete Section I before having Section II completed. The FMLA allows your employer to require that you submit a timely, complete, and sufficient medical certification to support your request for FMLA leave to care for a covered service member with a serious illness or injury.

If requested by your employer, completion of this certification is needed for you to get or keep the benefit of FMLA protections. 29 U.S.C. §§ 2613, 2614(c)(3). Failure to provide a complete and sufficient medical certification may result in a delay or denial of your FMLA request. 29 C.F.R. § 825.310(f). Your employer must give you at least 15 calendar days to return this form. 29 C.F.R. § 825.305(b).

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: ___________________________

How many hours are you scheduled to work each week? _______________

Please circle your scheduled work days: SAT SUN MON TUE WED THUR FRI

If your schedule varies each week, please check here: ☐

On the days that you work, are you scheduled to work the same number of hours each day?  ☐ Yes  ☐ No

What time are you scheduled to begin and end your work day? Begin _______________ End _______________

Are you paid overtime if you work more than 40 hours in a week?  ☐ Yes  ☐ No

Name of current service member (for whom the employee is requesting leave to provide care):

First: ___________________________ Middle: ___________________________ Last: ___________________________

Relationship of the employee to the current service member:

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

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1 This form may be used for certification of leave under the federal Family and Medical Leave Act (FMLA) as well as state leaves and employer’s company leaves.

2 Reference to your employer extends to Aetna in its capacity as your employer’s third party administrator.
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 a 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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Employee Signature ___________________________ Date __________
SECTION II: For completion by the HEALTH CARE PROVIDER

Please make sure that Section I has been completed before completing this section. Be sure to sign the form on the last page.

INSTRUCTIONS to the HEALTH CARE PROVIDER: The employee listed on page 1 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 or 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 “as medically necessary,” “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.

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 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. Please provide medical history information regarding your patient only to the extent necessary to fully respond to all relevant items below.

PART A: HEALTH CARE PROVIDER INFORMATION

Health Care Provider’s Name: ____________________________________________

Health Care Provider’s business address: __________________________________

Type of practice / Medical specialty: ________________________________________

Telephone: (________) ______________________________ Fax: (________)

Please indicate whether you are:

☐ A United States Department of Defense (DOD) health care provider
☐ A United States Department of Veterans Affairs (VA) health care provider
☐ A DOD TRICARE network authorized private health care provider
☐ A DOD non-network TRICARE authorized private health care provider
☐ A health care provider as defined in 29 CFR 825.125

3 A description of allowable Health Care Providers is listed in Part A.

4 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).
PART B: MEDICAL STATUS

1. The current service member’s medical condition is classified as (check one of the appropriate boxes):
   □ 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 a 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 service member medically unfit to perform the duties of the member’s office, grade, rank, or rating.
   □ NONE OF THE ABOVE (Note to the 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 section 825.113 of the FMLA. If such leave is requested, you may be required to complete a certification for that leave 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

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, please describe medical treatment, recuperation or therapy:

2. Will the service member need 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 If yes, please estimate the frequency and duration of the periodic care:
   FREQUENCY: _____ time(s) every: _____ □ week(s) _____ □ month(s)
   (Example: 1 time(s) every: _____ □ week(s) 3 □ month(s) to indicate “once every 3 months”)
   DURATION: _____ □ hour(s) _____ □ day(s) per episode
   (Example: _____ □ hour(s) 2 □ day(s) per episode to indicate “2 days per episode”)

Signature of Health Care Provider ___________________________ Date ____________

FML Cert-Service member
Page 4 of 4