Leaves of Absence Certification: Serious Injury or Illness of a Veteran for Military Caregiver Leave

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 veteran 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 veteran):

Name of Employee requesting leave to care for the current veteran:

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

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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 the veteran (for whom the employee is requesting leave to provide care):

First: ___________________ Middle: ___________________ Last: ___________________

Relationship of the employee to the veteran:

☐ 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: VETERAN INFORMATION

1. Date of veteran’s discharge: ______________________

2. Was the veteran dishonorably discharged or released from the Armed Forces (including the National Guard or Reserves)?
   ☐ Yes ☐ No

3. Please provide the veteran’s military branch, rank and unit at the time of discharge:
   ________________________________________________________________
   ________________________________________________________________
   ________________________________________________________________
   ________________________________________________________________

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

PART C: CARE TO BE PROVIDED TO THE VETERAN

Describe the care to be provided to the veteran and an estimate of the leave needed to provide the care:

______________________________________________________________
______________________________________________________________
______________________________________________________________
______________________________________________________________
______________________________________________________________
______________________________________________________________
______________________________________________________________
______________________________________________________________

Employee Signature ________________________ Date __________________
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 veteran. For purposes of FMLA military caregiver leave, a serious injury or illness incurred by a service member in the line of duty on active duty in the Armed Forces (or that 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 manifested itself before or after the service member became a veteran and is:

(i) A continuation of a serious injury or illness that was incurred or aggravated when the covered veteran was a member of the Armed Forces and rendered the service member unable to perform the duties of the service member’s office, grade, rank, or rating; or

(ii) A physical or mental condition for which the covered veteran has received a U.S. Department of Veterans Affairs Service Related Disability Rating (VASRD) of 50 percent or greater, and such VASRD rating is based, in whole or in part, on the condition precipitating the need for military caregiver leave; or

(iii) A physical or mental condition that substantially impairs the covered 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; or

(iv) An injury, including a psychological injury, on the basis of which the covered veteran has been enrolled in the Department of Veterans Affairs Program of Comprehensive Assistance for Family Caregivers.

A complete and sufficient certification to support a request for FMLA military caregiver leave due to a covered veteran’s serious injury or illness includes written documentation confirming that the veteran’s injury or illness was incurred in the line of duty on active duty or existed before the beginning of the veteran’s active duty and was aggravated by service 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 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 veteran’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.

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

PART B: MEDICAL STATUS

1. The veteran’s medical condition is (check one of the appropriate boxes):
   ☐ A continuation of a serious injury or illness that was incurred or aggravated when the covered veteran was a member of the Armed Forces and rendered the service member unable to perform the duties of the service member’s office, grade, rank, or rating.
   ☐ A physical or mental condition for which the covered veteran has received a U.S. Department of Veteran's Affairs Service Related Rating (VASRD) of 50% or higher, and such VASRD rating is based, in whole or in part, on the condition precipitating the need for military caregiver leave.
   ☐ A physical or mental condition that subsequently impairs the covered veteran’s ability to secure or follow a substantially gainful occupation by reason of 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 covered veteran is enrolled in the Department of Veterans Affairs Program of Comprehensive Assistance for Family Caregivers.
   ☐ 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 veteran 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 veteran undergoing medical treatment, recuperation or therapy for this condition?
   ☐ Yes ☐ No If yes, please describe medical treatment, recuperation or therapy:
   _____________________________________________________________

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 C: VETERAN’S NEED FOR CARE BY FAMILY MEMBER

“Need for care” encompasses both physical and psychological care. It includes situations where, for example, due to his or her serious injury or illness, the veteran is unable to care for his or her own basic medical, hygienic, or nutritional needs or safety, or is unable to transport him or herself to the doctor. It also includes providing psychological comfort and reassurance which would be beneficial to the veteran who is receiving inpatient or home care.

1. Will the veteran 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 veteran need periodic follow-up treatment appointments?
   - Yes  ☐  No  ☐
   If yes, estimate the treatment schedule:

   ____________________________________________________________

3. Is there a medical necessity for the veteran to have periodic care for these follow-up treatment appointments?
   - Yes  ☐  No  ☐

4. Is there a medical necessity for the veteran to have periodic care for other than scheduled follow-up treatment appointments (e.g., episodic flare-ups or medical conditions)?
   - 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 __________________