SAN JOSÉ STATE UNIVERSITY

CERTIFICATION FOR SERIOUS INJURY OR ILLNESS OF COVERED SERVICE MEMBER

Military Family Leave

HUMAN RESOURCES

Employee Support Services | One Washington Square | San José, CA 95192-0046 408-924-2250 | 408-924-1701 (fax)

Purpose of the Form

The FML permits an employer to require that you submit a timely, complete, and sufficient certification to support a request for FML leave due to a serious injury or illness of a covered service member. Your response is required to obtain or retain the benefit of FML protections. You have 15 calendar days from the date of your request for leave to return this form to your immediate supervisor. Failure to provide a complete and sufficient medical certification may result in a denial of your FML request.

Employees Instructions: Please complete this form as well as the Leave Request Form before submitting to your immediate supervisor. Several questions in this section seek a response as to the frequency or duration of a condition, treatment, etc. Be as specific as you can; terms such as "unknown," or "indeterminate" may not be sufficient to determine FML coverage

Section I for Completion by Employee and/or the COVERED SERVICE MEMBER for whom the Employee is		
Part A: Employee Information		
Employee Name:	Employee ID:	Home Phone:
Current mailing address:		
Department/College Name:		Campus Phone:
Name of covered service member:		
Relationship of covered service member to you:		
Is the covered 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:		
Part B: Covered Service member Information Is the covered service member a current member of the Armed Forces, National Guard or Reserves? ☐Yes ☐ No If yes, please provide the covered service member's military branch, rank and unit currently assigned to: Was the covered service member a veteran of the Armed Forces at any time during the period of 5 years preceding the date on which the veteran undergoes that medical treatment, recuperation, or therapy? ☐Yes ☐ No Is the covered 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 covered service member and an estimate of the leave needed to provide the care		
Employee Signature:		Date:

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 be sure to sign the form on the last page.

PART B: MEDICAL STATUS

Covered 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 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 FML. If such leave is requested, you may be required to complete DOL FORM WH-380 or an employer-provided form seeking the same information.)

Was the condition for which the covered service member is being treated incurred in line of duty on active duty in the armed forces? ☐ Yes ☐ No

Approximate date condition commenced: _____

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

Is the covered service member undergoing medical treatment, recuperation, or therapy? ☐ Yes ☐ No

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

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

Will the covered 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: _____

Will the covered service member require periodic follow-up treatment appointments? ☐ Yes ☐ No

If yes, estimate the treatment schedule: _____

Is there a medical necessity for the covered service member to have periodic care for these follow-up treatment appointments? ☐ Yes ☐ No

HEALTH CARE PROVIDER INFORMATION	
Name of Health Care Provider:	Specialty:
Address:	Phone:
State License Number	Licensed to practice in the state(s) of:
Signature:	Date: