UNIVERSITY of WASHINGTON
HUMAN RESOURCES

(not for HMC or UWMC staff)

Family and Medical Leave
Health Care Provider Certification of Serious Injury or Illness of Covered Service Member for Military Family Leave

Return the completed form to:

Campus HR Operations & Services
Roosevelt Commons West
Box 354963
4300 Roosevelt Way NE
Seattle, WA 98195-4963
Fax: (206) 685-0636
Email: hrleaves@uw.edu

Do not submit to your unit or department

Part 1: Employee Information *To be Completed By Employee*

Employee name:	EID:	Employee phone:	Employee email:

Department:	Manager's name:	Manager's email:

Name of covered service member you will care for:

Service member's relationship to you:
☐ Parent ☐ Child ☐ Spouse ☐ Domestic Partner
☐ Brother/Sister ☐ Grandchild ☐ Grandparent ☐ Next of Kin
Is this a "step" relationship (i.e. step parent, step brother, etc.)? ☐ No ☐ Yes

Is the covered service member a current member of the regular Armed Forces, the National Guard or Reserves? ☐Yes ☐No

If yes, please provide the following information for the covered service member:

Military branch:	Rank:	Current unit assignment:

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:

Is the covered service member on the temporary disability retired list (TDRL)? ☐ No ☐ Yes

Part 2: Care You Will Provide to the Covered Service Member *To be Completed By Employee*

Describe care you will provide to your family member:

I am requesting time off work ☐ No ☐ Yes
If Yes: From (date) to (date)

I am requesting a reduced work schedule as follows ☐ No ☐ Yes
If Yes hours/day for days/week until (date)

I am requesting an intermittent work schedule ☐No ☐Yes
If yes, describe requested schedule:

FACULTY ONLY I am requesting to use paid sick leave if I am eligible ☐No ☐Yes

Employee Signature

Date:

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PART 3: *To Be Completed by United States Department of Defense (DOD) Health Care Provider*

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.

Our employee has requested leave covered by the FMLA to care for a family member who is a member of the Regular Armed Forces, the National Guard, or the Reserves and who is undergoing medical treatment, recuperation, or therapy, is otherwise in outpatient status, or is otherwise on the temporary disability retired list because of a serious injury or illness. For purposes of FMLA covered leave, a serious injury or illness is one that was incurred in the line of duty on active duty that may render the service member medically unfit to perform the duties of his or her office, grade, rank, or rating. Certification to support a request for FMLA covered leave due to a service member's serious injury or illness includes written confirmation that the service member's injury or illness was incurred in the line of duty on active duty, and that the service member is undergoing treatment for such injury or illness by a health care provider as listed above.

If you are unable to provide some of the military-related determinations referenced below, you may rely upon determinations from an authorized DOD representative (such as a DOD recovery care coordinator).

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.

Health Care Provider Information

Health care provider's name:	Type of practice/medical specialty:	Telephone:

Business address:	Fax:	Email:

Check the appropriate box - I am a: ☐ DOD health care provider ☐ VA health care provider ☐ DOD TRICARE network authorized private health care provider ☐ DOD non-network TRICARE authorized private health care provider

☐ Other – Please explain:

Covered Service Member's Medical Status

The covered service member's medical condition is classified as

☐ **(VSI) Very Seriously Ill/Injured** – Illness/Injury is of such a severity that life is imminently endangered. Family members are requested at bedside immediately. (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. (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 service member 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 the FMLA, in which case you may need to complete a Certification of Health Care Provider for Family Member's Serious Health Condition form.

Was the condition for which you are treating the covered service member incurred in line of duty while on active duty in the armed forces?

☐ Yes ☐ No

Approximate duration of condition: From (date) to (date)

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

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

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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?

☐ No ☐ Yes

If yes, please estimate the approximate duration of condition: From (date) _____ to (date) _____

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

If yes, please estimate the treatment schedule:

Is there a medical necessity for the covered service member to have periodic care from a family member for these follow-up appointments?

☐ No ☐ Yes

Is there a medical necessity for the covered service member to have periodic care from a family member or a health care provider for other than scheduled follow-up treatment appointments (e.g., episodic flare-ups of a medical condition)? ☐ No ☐ Yes

If yes, please estimate the frequency and duration of the periodic care:

Signature of Health Care Provider

_____ Date: _____