TRISTAR®

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

Employee Name:		
Home Address:		
Home Telephone:	Cell Phone:	Other phone:
Employer Name:	Last Day Worked:	First Day Missed:

COMPLETE THE FOLLOWING STEPS:
STEP 1: Verify and complete all of the information above.
STEP 2: Give all pages to your Current Servicemember's Health Care Provider and instruct them to complete.
After the Health Care Provider has completed and signed the bottom,

- **fax the form to TRISTAR at 562/495-6687**
- **email the form to ICSFax@tristargroup.net**
- **mail the form to TRISTAR, 2835 Temple Avenue, Signal Hill, CA 90755**

TRISTAR only needs one copy of this form, so please choose one method of delivery only.

INSTRUCTIONS to the EMPLOYEE and/or the CURRENT SERVICEMEMBER:
The FMLA allows 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 covered servicemember. If requested by your employer, your response is required to obtain or retain the benefit of FMLA-protected leave. The employer must give an employee **at least 15 calendar days** to return this form to the employer. 29 U.S.C. §§ 2613, 2614(c)(3).

PART A: EMPLOYEE INFORMATION

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

_____
First Middle Last

(2) Select your relationship to the current servicemember. You are the current servicemember's:

☐ Spouse ☐ Parent ☐ Child ☐ Next of Kin

Spouse means a husband or wife as defined or recognized in the state where the individual was married, including a common law marriage or same-sex marriage. The terms "child" and "parent" include in loco parentis relationships in which a person assumes the obligations of a parent to a child. An employee may take FMLA leave to care for a covered servicemember who assumed the obligations of a parent to the employee when the employee was a child. An employee may also take FMLA leave to care for a covered servicemember for whom the employee has assumed the obligations of a parent. No biological or legal relationship is necessary. "Next of kin" is the servicemember's nearest blood relative, other than the spouse, parent, son, or daughter, in the following order of priority: (1) a blood relative as designated in writing by the servicemember for purposes of FMLA leave, (2) blood relatives granted legal custody of the servicemember, (3) brothers and sisters, (4) grandparents, (5) aunts and uncles, and (6) first cousins.

PART B: SERVICEMEMBER INFORMATION AND CARE TO BE PROVIDED TO THE SERVICEMEMBER

(3) The servicemember (☐ is /☐ is not) a current member of the Regular Armed Forces, the National Guard or Reserves.

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

_____

(4) The servicemember (☐ is /☐ is not) 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.

If yes, provide the name of the medical treatment facility or unit:

_____

(5) The servicemember (☐ is / ☐ is not) on the Temporary Disability Retired List (TDRL).

Employee Name:_____ Employer:_____

(6) Briefly describe the care you will provide to the servicemember: (*Check all that apply*)

☐ Assistance with basic medical, hygienic, nutritional, or safety needs
☐ Psychological Comfort ☐ Physical Care
☐ Transportation ☐ Other: _____

(7) Give your **best estimate** of the amount of leave needed to provide the care described:

_____

(8) If a **reduced work schedule** is necessary to provide the care described, give your **best estimate** of the reduced schedule you are able to work. From _____ *(mm/dd/yyyy)* to _____ *(mm/dd/yyyy),* I am able to work _____ (*hours per day*) _____ (*days per week).*

INSTRUCTIONS to the HEALTH CARE PROVIDER

Please provide your contact information, complete all Parts of this Section fully and completely, and sign the form below. The employee listed at Section I 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. Note: 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 the servicemember's office, grade, rank, or rating. "Need for care" includes both physical and psychological care. It includes situations where, for example, due to his or her serious injury or illness, the servicemember is not able to care for his or her own basic medical, hygienic, or nutritional needs or safety, or needs transportation to the doctor. It also includes providing psychological comfort and reassurance which would be beneficial to the servicemember who is receiving inpatient or home care. 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.

Please be sure to sign the form on the last page and return all three (3) pages to TRISTAR as instructed above.

PART A: HEALTH CARE PROVIDER INFORMATION

Health Care Provider's name: _____

Health Care Provider's business address: _____

Type of Practice / Medical specialty: _____

Telephone: (_____)_____ Fax: (_____)_____ Email: _____

Please select the type of FMLA health care provider you are:

☐ 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
☐ Health care provider as defined in 29 C.F.R. § 825.125

PART B: MEDICAL INFORMATION

Please provide appropriate medical information of the patient as requested below. Limit your responses to the servicemember's condition for which the employee is seeking leave. If you are unable to make some of the military-related determinations contained below, you are permitted to rely upon determinations from an authorized DOD representative, such as a DOD recovery care coordinator. Do not provide information about genetic tests, as defined in 29 C.F.R. § 1635.3(f), or genetic services, as defined in 29 C.F.R. §1635.3(e).

(1) Patient's Name: _____

(2) List the approximate date condition started or will start: _____*(mm/dd/yyyy*)

Employee Name:_____ Employer:_____

(3) Provide your **best estimate** of how long the condition will last: _____

(4) The servicemember's injury or illness: (*Select as appropriate*)

- ☐ Was incurred in the line of duty on active duty.
- ☐ Existed before the beginning of the servicemember's active duty and was aggravated by service in the line of duty on active duty.
- ☐ None of the above.

(5) The servicemember (☐ is / ☐ is not) undergoing medical treatment, recuperation, or therapy for this condition.
If yes, briefly describe the medical treatment, recuperation or therapy: _____
_____

(6) The current servicemember's medical condition is classified as: (*Select as appropriate*)

☐ **(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 29 C.F.R. § 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.*

PART C: AMOUNT OF LEAVE NEEDED

For the medical condition checked in Part B, complete all that apply. Some 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.

(7) Due to the condition, the servicemember will need care for a **continuous period of time**, including any time for treatment and recovery. Provide your **best estimate** of the beginning date _____ (*mm/dd/yyyy*) and end date _____ (*mm/dd/yyyy*) for this period of time.

(8) Due to the condition, it is medically necessary for the servicemember to attend **planned medical treatment** appointments (scheduled medical visits). Provide your **best estimate** of the duration of the treatment(s), including any period(s) of recovery _____ (*e.g. 3 days/week)*

(9) Due to the condition, it is medically necessary for the servicemember to receive care on an **intermittent basis** (periodically), such as the care needed because of episodic flare-ups of the condition or assisting with the servicemember's recovery. Provide your **best estimate** of how often (frequency) and how long (the duration) the intermittent episodes will likely last.

Over the next 6 months, intermittent care is estimated to occur _____ times per (☐ day / ☐ week / ☐ month) and are likely to last approximately _____ (☐ hours / ☐ days) per episode.

_____ _____

Signature of Health Care Provider **Date**

PAPERWORK REDUCTION ACT NOTICE AND PUBLIC BURDEN STATEMENT

If submitted, it is mandatory for employers to retain a copy of this disclosure in their records for three years, in accordance with 29 U.S.C. 2616; 29 CFR 825.500. Persons are not required to respond to this collection of information unless it displays a currently valid OMB control number. The Department of Labor estimates that it will take an average of 20 minutes for respondents to complete this collection of information, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. If you have any comments regarding this burden estimate or any other aspect of this collection information, including suggestions for reducing this burden, send them to the Administrator, Wage and Hour Division, U.S. Department of Labor, Room S-3502, 200 Constitution Ave., NW, Washington, DC 20210.

DO NOT SEND THE COMPLETED FORM TO THE DEPARTMENT OF LABOR
Please return the form to TRISTAR as instructed on page 1.