

Please return completed form to:
 Idaho State University
 Office of Human Resources
 921 South 8th Ave., Stop 8107
 Pocatello, ID 83209-8107



**Certification of Serious Injury or Illness of Covered Servicemember
 (Family and Medical Leave Act)**

Section I – Contact Information (to be completed by Idaho State University)

Employer Contact Name

Section II – Employee Information (to be completed by employee)

Employee Name

Name of covered servicemember (for whom employee is requesting leave to care)

Relationship of Covered servicemember requesting leave to care

Spouse Parent Son Daughter Next of Kin

Part A – Covered servicemember Information (to be completed by employee)

Is the Covered servicemember a Current Member of the Regular Armed Forces, the National Guard or Reserves? [] Yes [] No

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

Is the covered servicemember 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

Is the Covered servicemember on the Temporary Disability Retired List (TDRL)? [] Yes [] No

Part B – Care to be provided to the covered servicemember (to be completed by employee)

Describe the Care to Be Provided to the Covered servicemember and an Estimate of the Leave Needed to Provide the Care:

SECTION III: 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 ensure that Section II above has been completed before completing this section.) Please be sure to sign the form on the last page.

Part A – Healthcare Provider Information

Provider's Name

Address

City

State

Zip Code

Telephone Number

Fax Number

Type of practice / Medical specialty

Please state whether you are either: (1) a DOD health care provider; (2) a VA health care provider; (3) a DOD TRICARE network authorized private health care provider; or (4) a DOD non-network TRICARE authorized private health care provider:

Part B – Medical Status

Covered servicemember'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 FMLA. 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 servicemember undergoing medical treatment, recuperation, or therapy?
 Yes No

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

Part B – Covered Servicemember's need for care by family member

Will the covered servicemember 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 servicemember require periodic follow-up treatment appointments? Yes No

If yes, estimate the treatment schedule:

Is there a medical necessity for the covered servicemember to have periodic care for these follow-up treatment appointments?

Is there a medical necessity for the covered servicemember to have periodic care for other than scheduled follow-up treatment appointments (e.g., episodic flare-ups of medical condition)?
 Yes No

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

Signature of Health Care Provider

Date