WASHINGTON STATE UNIVERSITY

MILITARY FAMILY LEAVE

HEALTH CARE PROVIDER STATEMENT

COVERED SERVICEMEMBER

Please return form to:	Human Resource Services (HRS)
Electronic (scan or photo):	HRS.Disabilityservices@wsu.edu
OR Fax:	509-241-9090
Office Location:	139 French Administration Bldg.
OR Mailing address:	PO Box 641014, Pullman, WA 99163
Questions? Call HRS at:	509-335-4521

EMPLOYEE complete section A

A | EMPLOYEE INFORMATION

Employee Name (Last, First, MI)

HEALTH CARE PROVIDER complete sections B through D

Sections B - D For completion by: (1) a United States Department of Defense ("DOD") health care provider; (2) a United States Department of Veterans Affairs ("VA") health care provider; (3) a DOD TRICARE network authorized private health care provider; (4) a DOD non-network TRICARE authorized private health care provider; or (5) a health care provider as defined in 29 CFR 825.125.

The employee named in Section A has requested leave under the military caregiver leave provision of the Family Medical Leave Act (FML) 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. For purposes of FML, 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 servicemember'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 his/her office, grade, rank, or rating.

You are being requested to complete this form as a complete and sufficient certification to support a request for FML due to a current servicemember's serious injury or illness includes written documentation confirming the above by a health care provider.

B | CERTIFICATION OF MEDICAL STATUS

The current servicemember's medical condition is classified as: (Check the appropriate box)

☐ **(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." (Please contact HRS for more information.)

Note: If you are unable to make certain of the military-related determinations contained in Part B, you are permitted to rely upon determinations from an authorized DOD representative (such as, DOD Recovery Care Coordinator) or an authorized VA representative.

Is the current servicemember 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

Please describe medical treatment, recuperation, or therapy:

Employee Name (Last, First, MI)

C CERTIFICATION OF NEED FOR CARE BY FAMILY MEMBER

"Need for care" encompasses both physical and psychological care. It includes situations where, for example, due to his/her serious injury or illness, the servicemember is unable to care for his/her own basic medical, hygienic, or nutritional needs or safety, or is unable to transport him/herself 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.

FULL-TIME LEAVE

Will the current servicemember require care for a single full-time period of time? ☐ Yes ☐ No

Begin date condition prevents employee from working on a full time due to care required: ___/____/_____

Date care no longer needed, if known: _____/_____/____

If end date unknown, date of next evaluation: _____/_____/_____

PART-TIME LEAVE

Will the current servicemember need care on a part-time basis? ☐ Yes ☐ No

If Yes, Begin date ____/____/____ through ____/____/____ date

Identify the part-time or reduced work schedule needed by the employee to provide care:

______hour(s) per day; ______day(s) per week

Or describe:

INTERMITTENT LEAVE

Will the condition cause the current servicemember to require care on an intermittent/episodic basis, periodically causing the current servicemember to require care by the family member listed in section A?
☐ Yes ☐ No

If Yes, Begin date ____/____/____

Estimate the frequency and duration of episodic need for care caused by flare-ups or follow-ups appointments (e.g. 1 time per 2 months for 3-4 days per episode)

Frequency: _____time(s) per_____ week(s)_____month(s) **Duration:** _____hour(s) or _____day(s) per episode

Identify the number of months the employee may need intermittent leave to provide care **(select one):**
☐ 3 months ☐ 6 months ☐ 9 months ☐ 12 months ☐ Other period of time (up to 12 months) ___________

Or describe:

D HEALTH CARE PROVIDER INFORMATION

Name of Health Care Provider *(please print or type)*	Health Care Provider Signature	Date
Health Care Provider Street Address	City, State Zip	
Type of Practice	Telephone	Fax

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. To comply with this law, we are asking that you do 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."