WASHINGTON STATE UNIVERSITY

MILITARY FAMILY LEAVE

HEALTH CARE PROVIDER STATEMENT

COVERED VETERAN

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 covered veteran with 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 or existed before the beginning of the veteran's active duty and was aggravated by service in the line of duty, on active duty, and that the veteran is undergoing treatment, recuperation, or therapy for such injury or illness by a health care provider listed above.

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

B CERTIFICATION OF MEDICAL STATUS

The veteran's medical condition is: (Check the appropriate box)

- ☐ A continuation of a serious injury or illness that was incurred or aggravated when the covered veteran was a member of the Armed Forces and rendered the servicemember unable to perform the duties of the service-member's office, grade, rank, or rating.
- ☐ A physical or mental condition for which the covered veteran has received a U.S. Department of Veterans Affairs Service Related Disability Rating (VASRD) of 50% or higher, and such VASRD rating is based, in whole or in part, on the condition precipitating the need for military caregiver leave.
- ☐ A physical or mental condition that substantially impairs the covered veteran's ability to secure or follow a substantially gainful occupation by reason of a disability or disabilities related to military service, or would do so absent treatment.
- ☐ An injury, including a psychological injury, on the basis of which the covered veteran is enrolled in the VA Program of Comprehensive Assistance for Family Caregivers.
- ☐ None of the above.

Note: If you are unable to make certain of the military-related determinations contained in section 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 veteran 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 or her serious injury or illness, the veteran is unable to care for his or her own basic medical, hygienic, or nutritional needs or safety, or is unable to transport him or herself to the doctor. It also includes providing psychological comfort and reassurance which would be beneficial to the veteran who is receiving inpatient or home care.

FULL-TIME LEAVE

Will the veteran require care for a single period on a full-time basis? ☐ 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 veteran 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 veteran to require care on an intermittent/episodic basis, periodically causing the veteran 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."