FLORIDA STATE COLLEGE AT JACKSONVILLE

Certification for Serious Injury/Illness of Covered Servicemember - Military Family Leave
(Family and Medical Leave Act)

SECTION I: For Completion by the EMPLOYEE and/or the COVERED SERVICEMEMBER for whom the Employee Is Requesting Leave: (This section must be completed first before any of the below sections can be completed by a health care provider.)

Part A: EMPLOYEE INFORMATION

Employer Name: Florida State College at Jacksonville, Attn: Benefits Office

Employer Address: 501 W State Street, Jacksonville, FL 32202, Room 103

Confidential Fax: (904) 632-3329 Phone: (904) 632-3018

Name of Employee Requesting Leave to Care for Covered Servicemember:

_____ _____
First Middle Last EMPLID

Name of Covered Servicemember (for whom employee is requesting leave to care):

_____
First Middle Last

Relationship of Employee to Covered Servicemember Requesting Leave to Care:
☐ Spouse ☐ Parent ☐ Son ☐ Daughter ☐ Next of Kin
Please Note: Proof of relationship may be requested.

Part B: COVERED SERVICEMEMBER INFORMATION

(1) 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
If yes, please provide the name of the medical treatment facility or unit: _____

(2) Is the Covered Servicemember on the Temporary Disability Retired List (TDRL)?____Yes____No

Part C: CARE TO BE PROVIDED TO THE COVERED SERVICEMEMBER

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

_____

_____

SECTION II: 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 nonnetwork 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 I above has been completed before completing this section.) Please be sure to sign the form on the last page.

Part A: HEALTH CARE PROVIDER INFORMATION

Provider's name: _____
(Please Print)
Provider's business address: _____

Type of practice / Medical specialty: _____

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

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

(1) Covered Servicemember's medical condition is classified as (Check One of the Appropriate Boxes):

☐ **VERY SERIOUSLY ILL/INJURED (VSI)** – 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.)

☐ **SERIOUSL ILL/INJURED (SI)** – 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 FCCJ FORM FMLA2, Family and Medical Leave Request.)

(2) 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

(3) Approximate date condition commenced: _____

(4) Probable duration of condition and/or need for care: _____

(5) Is the covered servicemember undergoing medical treatment, recuperation, or therapy?____Yes____No
If yes, please describe medical treatment, recuperation or therapy: _____

PART C: COVERED SERVICEMEMBER'S NEED FOR CARE BY FAMILY MEMBER

(1) 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: _____

(2) Will the covered servicemember require periodic follow-up treatment appointments?
____Yes____No

If yes, estimate the treatment schedule: _____

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

(4) 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**