FAMILY MEDICAL LEAVE

SOUTH GEORGIA MEDICAL CENTER

Human Resources

Military Servicemember's Serious Health Condition Certification of Health Care Provider Form

Under the Family and Medical Leave Act (FMLA), a qualified employee with a covered, seriously ill military servicemember may be entitled to up to 26 weeks leave during a 12-month period. See these FAQ for details. An employee seeking leave to care for a seriously ill military servicemember may be required to submit a medical certification documenting the servicemember's serious health condition. This form seeks information from you, as the employee, and from the U.S. Department of Defense-approved health care provider of the seriously ill servicemember.

SECTION I: Employer, Employee and Covered Servicemember

Instructions: This Certification is required to obtain or retain the benefit of FMLA protections. Failure to provide a timely, complete and sufficient medical certification may result in a denial of your FMLA request. Please complete this section before giving this form to your seriously ill servicemember, or to his or her health care provider. **Please print or type** your responses. The completed form must be returned to the Human Resources at SMGC within **15 calendar days** from the date of your receipt of this notice.

PART A: EMPLOYER & EMPLOYEE INFORMATION

Employer Name: Hospital Authority of Lowndes County d/b/a South Georgia Medical Center

Employer Contact: Alberta Graham, Human Resources Department, (229) 259-4713

Employee Name: _____ Employee #: _____
First Middle Last

Servicemember Name: _____ Relationship: _____
First Middle Last

Relationship of Employee to Covered Servicemember: ❒ Spouse ❒ Parent ❒Son ❒ Daughter ❒ Next of Kin

PART B: MILITARY 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

2) Is the Covered Servicemember on the Temporary Disability Retired List (TDRL)? ❒ Yes ❒ No

Part C: CARE TO BE PROVIDED TO THE MILITARY SERVICEMEMBER

Describe the care you provide to your family member, and **estimate how much leave** will be needed.

_____

_____

_____

Employee Signature: _____ Date: _____

SECTION II: Health Care Provider (*For completion by a U.S. Department of Defense ("DOD") Health Care Provider or a health Care Provider who is either: (1) a U.S. Department of Veterans Affairs ("VA") health care provider; (2) a DOD TRICARE network authorize 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 n Part B, you are permitted to rely upon determinations from an authorized ODD 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.*

Instructions: *Our employee, named above, has requested leave under the FMLA to care for your patient, a Covered Military Servicemember. Please answer, fully and completely, all applicable parts below. Several 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. Limit your responses to the condition for which the patient needs leave. Space is provided for you to supply additional information, should you wish to do so. Please be sure to* ***type or print*** *your response, and to sign the form where indicated.*

PART A: HEALTH CARE PROVIDER INFORMATION

Provider's name: _____

Business address: _____

Type of Practice/Medical Specialty: _____

Telephone: _____ Fax: _____

Please indicate whether you are:

- ❒ a DOD health care provider;
- ❒ a DOD TRICARE network authorized private health care provider; or
- ❒ a DOD non-network TRICARE authorize private health care provider
- ❒ a VA health care provider

PART B: MEDICAL STATUS

(1) Covered Military Servicemember's medical condition is classified as: (Check one of the appropriate boxes):

- ❒ **(VSI) Very Seriously 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); **OR**

PART B: MEDICAL STATUS (continued

(1) Covered Military Servicemember's medical condition is classified as (Check one of the appropriate boxes):

❒ **(SI) Seriously Injured** – Illness/injury is of such a severity that there is cause for immediate concern, but there is no imminent danger to life. Family members are request at bedside. (Please note this is an internal DOD casualty assistance designation used by DOD healthcare providers.); OR

❒ **OTHER ILL / Injured** – a seriously injury or illness that may render the servicemember medically unfit to perform the duties of the member's office, grade, rank or rating; OR

❒ (NONE OF THE ABOVE – (Note to Employee: Even 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 you would like to request such leave, please complete the SGMC form entitled, **Family Member's Serious Health Condition, Certification of Health Care Provider."**

(2) Was the condition for which the Covered Servicemember is being treated incurred in the 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:

From: _____ To: _____

(2) Will the Covered Servicemember require periodic follow up treatment appointments? ❒ Yes ❒ No

If yes, estimate the treatment _____

(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 appoints (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 _____

Please Return to Alberta Graham
Human Resources Department
P O Box 1727 --- Valdosta, GA 31603-1727
Phone (229) 259 – 4713 Fax (229) 259-4701