CALHR
CALIFORNIA DEPARTMENT OF HUMAN RESOURCES

Certification for Serious Injury or Illness of Covered Service Member (FMLA)

California Department of Human Resources
State of California

Print Form Reset Form

MILITARY FAMILY CAREGIVER LEAVE

Part A. For Completion by the Employee

Employee Last Name | Employee First Name | Employee Middle Name

Employee Work Unit | Contact Telephone Number

Name of covered servicemember for whom employee is requesting Caregiver Leave:

Last Name | First Name | Middle Name

Your relationship to the covered service member: ☐ Spouse ☐ Parent ☐ Child ☐ Next of Kin

Part B. Covered Servicemember Information

1. Is the covered servicemember a current member of the Regular Armed Forces, the National Guard, Reserves or a Veteran of the Armed Forces including the National Guard and Reserves at any time within 5 years preceding treatment? ☐ Yes ☐ No

   If Yes, please provide the servicemember's:

   Military Branch | Rank | Unit Currently Assigned (if applicable)

2. 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:

3. Is the covered servicemember on the Temporary Disability Retired List? ☐ Yes ☐ No

Part C. Care to be Provided to the Covered Servicemember

1. Describe the care to be provided to the covered servicemember.

2. Estimate the amount of leave needed to provide care.

Part D. Third Party Information

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 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 Parts A, B, and C above are completed before completing this section. Please be sure to sign and date the form on the last page**

Provider Name (You may attach a business card in lieu of completing this section):

Business Address	City	State	Zip Code

Type of Practice / Medical Specialty

Telephone	Fax

1. Covered servicemember's medical condition is classified as: (Check One)

☐ **(VSI) Very seriously ill/injured**
Illness/injury is of such a severity that life is imminently endangered. Family is requested at bedside immediately. (Please note this is an internal DOD casualty assistance designation used by DOD health care 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 health care providers.)

☐ **OTHER ill/injured**
A serious injury or illness that may render the service member 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 a leave is requested, you may be required to complete the applicable request form.)

2. Was the condition for which the covered servicemember 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 the medical treatment, recuperation, or therapy:

Part E. 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:
_____ to _____
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 medication condition)? ☐ Yes ☐ No

If Yes, please estimate the frequency and duration of the periodic care _____

Part F. Signature

Printed Name of Health Care Provider _____

_____ _____

Health Care Provider Signature | Date/Time

Privacy Notice

This notice is provided pursuant to the Information Practices Act of 1977.

The California Department of Human Resources (CalHR), Personnel Management Division is requesting the information specified on this form.

The information collected will be used for purposes of determining your eligibility for FMLA benefits.

Individuals should not provide personal information that is not requested or required.

The submission of all information requested is mandatory unless otherwise noted. If you fail to provide the information requested, there may be a delay in processing your request.

Department Privacy Policy

The information collected by CalHR is subject to the limitations in the Information Practices Act of 1977 and state policy. For more information on how we care for your personal information, please read our Privacy Policy on CalHR's website (calhr.ca.gov).

Access to Your Information

Information provided on this form will be maintained by the CalHR Personnel Management Division pursuant to State Administrative Manual retention requirements. Individuals have the right of access to copies of this form on request. Send requests to:

Personnel Management Division
Department of Human Resources
1515 S Street, Suite 500N
Sacramento, CA 95811