State of Michigan
Department of Corrections

CERTIFICATION OF SERIOUS INJURY OR ILLNESS OF COVERED SERVICEMEMBER

SECTION I – For completion by employee. You must submit a complete certification to support your request for FMLA leave due to a serious illness of injury to a covered servicemember within 15 calendar days. Not doing so may result in denial of your request. Please complete Section I before having Section II completed.

1. Employee's Full Name	2. Covered Servicemember's Full Name

3. Name and Address of Employee's Employer

4. Relationship of Employee to Covered Servicemember: ☐ Spouse ☐ Parent ☐ Child ☐ Next of Kin

5. Is the servicemember a current member or veteran of the regular Armed Forces, National Guard, or Reserves?
☐ Yes ☐ No
If yes, please provide the servicemember's military branch, rank, and any unit currently assigned to:

6. Is the 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 a medical hold or warrior transition unit)? ☐ Yes ☐ No
If yes, please provide the name of the medical treatment facility or unit:

7. Is the servicemember on the Temporary Disability Retired List (TDRL)? ☐ Yes ☐ No

8. Describe the care to be provided to the servicemember and estimate the leave needed to provide the care:

SECTION II – For completion by (1) U.S. Department of Defense (DOD) health care provider (HCP), (2) U.S. Department of Veterans Affairs (VA) HCP, (3)DOD TRICARE network authorized private HCP, or (4) DOD non-network TRICARE authorized private HCP. The employee listed in Section I has requested leave under the FMLA to care for a relative who is a covered servicemember. Answer fully and completely all applicable parts. Please answer all questions based on your medical knowledge, experience, and examination of the patient. Be as specific as you can, but limit your responses to the condition for which the employee is seeking leave. If you cannot make any military-related determination, you may rely upon determinations from an authorized DOD representative. Please ensure that Section I above has been completed before completing this section. Please be sure to sign the form.)

1. Health Care Provider's Name and Business Address		2. Type of Practice Medical Specialty
3. Telephone:	4. Fax:	5. Email:

6. Indicate which type of health care provider (HCP) you are: ☐ a DOD HCP ☐ a VA HCP
☐ a DOD TRICARE network authorized private HCP ☐ a DOD non-network TRICARE authorized private HCP

7. The covered servicemember's medical condition is classified as (check one):

☐ **Very Seriously Ill/Injured (VSI) –** Illness/Injury is of such a severity that life is imminently endangered. Family members are requested at bedside immediately.

☐ **Seriously Ill/Injured (SI)** – 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 requested at bedside.

☐ **Other Ill/Injured –** A serious illness/Injury that may render the servicemember medically unfit to perform the duties of the member's office, grade, rank, or rating.

☐ **None of the Above**

8. Was the condition for which the servicemember is being treated incurred in or aggravated by service in line of duty on active duty in the armed forces? ☐ Yes ☐ No

9. Approximate date condition commenced:	10. Probable duration of condition and/or need for care:

11. Is the servicemember undergoing medical treatment, recuperation, or therapy? ☐ Yes ☐ No
If yes, please describe:

12. Will the servicemember need care for a single continuous period of time, including any time for treatment or recovery? ☐ Yes ☐ No
If yes, please estimate the beginning and ending dates for this period:

13. Will the servicemember require periodic follow-up treatment? ☐ Yes ☐ No
If yes, please estimate the treatment schedule:

14. Is there a medical necessity for the servicemember to have periodic care for these follow-up treatment appointments? ☐ Yes ☐ No

15. Is there a medical necessity for the 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**