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| DOTLOGOMISSOURI DEPARTMENT OF TRANSPORTATIONCERTIFICATION FOR SERIOUS INJURY OR ILLNESS OF COVERED SERVICEMEMBERFAMILY AND MEDICAL LEAVE ACT (FMLA) LEAVE |

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| **SECTION I**: For completion by the **Employee and/or the Covered Servicemember for whom the employee is requesting leave** |
| Please read and complete Section I before having Section II completed. The FMLA permits MoDOT to require that an employee submit a timely, complete, and sufficient certification to support a request for FMLA leave due to a serious injury or illness of a covered servicemember. Your response is required to obtain or retain the benefit of FMLA-protected leave. Failure to do so may result in a denial of your FMLA request. You must provide the completed certification (or an explanation of why you have been unable to complete the certification) within 15 calendar days. |

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| **PART A:** EMPLOYEE AND COVERED SERVICEMEMBER INFORMATION |
| Name and address of **employer** (of the employee requesting leave to care for covered servicemember):  |
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| Full name of **employee** requesting leave to care for covered servicemember: |
|  |       |
| Full name of **covered servicemember** (for whom employee is requesting leave to care): |
|  |       |
| Relationship of employee to covered servicemember requesting leave to care: |
| [ ]  | Spouse | [ ]  | Parent | [ ]  | Son | [ ]  | Daughter | [ ]  | Next of Kin |
| 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: |       |
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| 2. Is the covered servicemember on the Temporary Disability Retired List (TDRL)? | [ ]  Yes | [ ]  No |
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| 3. The veteran was ([ ]  honorably / [ ]  dishonorably) discharged or released from the Armed Forces,  |
| including the National Guard or Reserves. |
| List the date of the veteran’s discharge |       | *(mm/dd/yyyy)* |
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| 4. Please provide the veteran’s military branch, rank and unit at the time of discharge:  |
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| **PART B:** 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: |       |
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| **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 non-network 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).**The employee listed on Page 1 has requested leave under the FMLA to care for a family member who is a member of the Regular Armed Forces, the National Guard, or the Reserves who is undergoing medical treatment, recuperation, or therapy, is otherwise in outpatient status, or is otherwise on the temporary disability retired list for a serious injury or illness. For purposes of FMLA leave, a serious injury or illness is one that was incurred in the line of duty on active duty that may render the servicemember medically unfit to perform the duties of his or her office, grade, rank, or rating.A complete and sufficient certification to support a request for FMLA leave due to a covered servicemember’s serious injury or illness includes written documentation confirming that the covered servicemember’s injury or illness was incurred in the line of duty on active duty and that the covered servicemember is undergoing treatment for such injury or illness by a health care provider listed above. Answer, fully and completely, all applicable parts. 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 employee is seeking leave.Please ensure that Section I has been completed before completing this section. **Please be sure to sign the form on the last page.** |

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| **PART A:** HEALTH CARE PROVIDER INFORMATION |
| Health care provider’s name: |       |
| Provider’s business address: |       |
| Type of practice/medical specialty: |       |
| Please indicate which of the following you are: |
| [ ]   | a DOD health care provider |
| [ ]   | a VA health care provider |
| [ ]   | a DOD TRICARE network authorized private health care provider |
| [ ]   | a DOD non-network TRICARE authorized private health care provider |
| Telephone: |       | Fax: |       | Email: |       |

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| **PART B:** MEDICAL STATUS |
| 1. Covered servicemember’s medical condition is classified as (check one of the appropriate boxes): |
| [ ]   | **(VSI) Very Seriously Ill/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 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 servicemember medically unfit to perform the duties of the servicemember’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 the FMLA. If such leave is requested, you may be required to complete MoDOT Form FMLA3B - Certification for Family Member’s Serious Health Condition.*) |
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| 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 |
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| 3. Approximate date condition commenced: |       |
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| 4. Probable duration of condition and/or need for care: |       |
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| 5. Is the covered servicemember undergoing medical treatment, recuperation, or therapy? | [ ]  Yes | [ ]  No |
| If yes, please describe medical treatment, recuperation, or therapy: |       |
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| **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: |       |
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| 2. Will the covered servicemember require periodic follow-up treatment appointments? | [ ]  Yes | [ ]  No |
| If yes, estimate the treatment schedule: |       |

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| **PART C, cont.:** COVERED SERVICEMEMBER’S NEED FOR CARE BY FAMILY MEMBER |
| 3. Is there a medical necessity for the covered servicemember to have periodic care for these follow-up  |
| treatment appointments? | [ ]  Yes | [ ]  No |
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| 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: |       |
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| **Signature of Health Care Provider** |  | **Date** |

Return completed form to the patient.

The privacy of all personal and medical information must be protected at all times. This form may contain confidential personal or medical information. Confidentiality of personal and medical information must be maintained at all times and may not be shared with anyone except those required.

NOTE: The Genetic Information Nondiscrimination Act (GINA) prohibits employers and other entities covered by GINA Title II from requesting or requiring genetic information of employees or their family members. In order to comply with this law, we are asking that you 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.