

NALC Form 5 Family and Medical Leave Act Form

Employee: Return the completed form to the appropriate FMLA administration HRSSC address or fax (see attached sheet) and keep a copy for your own records.

Certification for Serious Injury or Illness* of a Veteran for Military Caregiver Leave (FMLA)

Section 1: For completion by the employee and/or the veteran for whom the employee is requesting leave.

A. Name (First, Middle, and Last) of the employee requesting leave to care for veteran:

EIN: _____ FMLA Case # (if known): _____

B. Name (First, Middle, and Last) of veteran (for whom employee is requesting leave to care for):

C. Relationship of veteran to employee:

☐ Spouse ☐ Parent ☐ Son ☐ Daughter ☐ Next of Kin

D. Veteran Information

1) Date of the veteran's discharge: _____

2) Was the veteran **dishonorably** discharged or released from the Armed Forces (including the National Guard or Reserves)?

☐ Yes ☐ No

3) Please provide the veteran's military branch, rank and unit at the time of discharge:

4) Is the veteran receiving medical treatment, recuperation or therapy for an injury or illness? ☐ Yes ☐ No

E. Describe the care to be provided to the veteran and an estimate of the leave needed to provide the care:

*SERIOUS INJURY OR ILLNESS—A serious injury or illness means an injury or illness incurred by the servicemember in the line of duty on active duty in the Armed Forces (or that existed before the beginning of the servicemember's active duty and was aggravated by service in the line of duty on active duty in the Armed Forces) and manifested itself before or after the servicemember became a veteran, and is:

(i) a continuation of a serious injury or illness that was incurred or aggravated when the covered veteran was a member of the Armed Forces and rendered the servicemember unable to perform the duties of the servicemember's office, grade, rank, or rating; or

(ii) a physical or mental condition for which the covered veteran has received a U.S. Department of Veterans Affairs Service Related Disability Rating (VASRD) of 50 percent or greater, and such VASRD rating is based, in whole or in part, on the condition precipitating the need for military caregiver leave; or

(iii) a physical or mental condition that substantially impairs the covered veteran's ability to secure or follow a substantially gainful occupation by reason of a disability or disabilities related to military service, or would do so absent treatment; or

(iv) an injury, including a psychological injury, on the basis of which the covered veteran has been enrolled in the Department of Veterans' Affairs Program of Comprehensive Assistance for Family Caregivers.

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Employee: Return the completed form to the appropriate FMLA administration HRSSC address or fax (see attached sheet) and keep a copy for your own records.

Certification for Serious Injury or Illness* of a Veteran for Military Caregiver Leave (FMLA)

Section 2: For completion by 1) a United States Department of Defense ("DOD") health care provider or health care provider who is either: 2) a United States Department of Veterans Affairs ("VA") health care provider, 3) a DOD TRICARE network authorized private health care provider, 4) a DOD non-network TRICARE authorized private health care provider, or 5) a health care provider under the FMLA (as defined in 29 CFR 825.125). Please be sure to sign the form in the place provided at the end.

A. Health care provider information

Health care provider's name (please print): _____

Health care provider's business address: _____

Telephone: (____) _____ Fax: _____ Email: _____

Type of practice/medical specialty: _____

Please indicate whether you are: ☐ 1. a DOD health care provider ☐ 2. a VA health care provider
☐ 3. a DOD TRICARE network authorized provider ☐ 4. a DOD non-network TRICARE authorized healthcare provider
☐ 5. a health care provider under the FMLA

B. Medical status

If you are unable to make certain of the military-related determinations contained in Part B below, you are permitted to rely upon determinations from an authorized DOD representative (such as a DOD recovery care coordinator) or an authorized VA representative.

1) The Veteran's medical condition is:

- ☐ A continuation of a serious injury or illness that was incurred or aggravated when the covered veteran was a member of the Armed Forces and rendered the servicemember unable to perform the duties of the servicemember's office, grade, rank, or rating.
☐ A physical or mental condition for which the covered veteran has received a U.S. Department of Veterans Affairs Service Related Disability Rating (VASRD) of 50% or higher, and such VASRD rating is based, in whole or in part, on the condition precipitating the need for military caregiver leave.
☐ A physical or mental condition that substantially impairs the covered veteran's ability to secure or follow a substantially gainful occupation by reason of a disability or disabilities related to military service, or would do so absent treatment.
☐ An injury, including a psychological injury, on the basis of which the covered veteran is enrolled in the Department of Veterans' Affairs Program of Comprehensive Assistance for Family Caregivers.

2) Is the veteran being treated for a condition which was incurred or aggravated by service 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 veteran undergoing medical treatment, recuperation, or therapy for this condition? ☐ Yes ☐ No

If yes, please describe medical treatment, recuperation or therapy:

C. Veteran's need for care by family member

1) Does the patient require assistance for basic medical, hygiene, nutritional needs, safety, transportation? ☐ Yes ☐ No

2) If no, would the employee's presence to provide psychological comfort be beneficial to the patient or assist in the patient's recovery? ☐ Yes ☐ No

3) Will the veteran 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: _____

4) Will the veteran require periodic follow-up treatment appointments? ☐ Yes ☐ No.

If yes, estimate the treatment schedule: _____

5) Is there a medical necessity for the veteran to have periodic care for these follow-up treatment appointments? ☐ Yes ☐ No

6) Is there a medical necessity for the veteran 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 (e.g.: 2 times per week for 8 months lasting 1 day):

Frequency: _____ times per _____ week(s) _____ month(s)

Duration: _____ hour(s) or _____ day(s) per event.

Signature of health care provider: _____ Date: _____