Pima County Family and Medical Leave (FML)
Medical Certification from Health Care Provider for Covered Servicemember's Serious Health Condition

FORM **MC-03** 09/2015

PIMA COUNTY

SECTION I: TO BE COMPLETED BY THE EMPLOYER

Employer Name: Pima County Contact: Human Resources - FMLA 520-724-8076 **Fax: 520-791-6514**

SECTION II: TO BE COMPLETED BY THE EMPLOYEE AND/OR THE COVERED SERVICEMEMBER

Please complete this section before giving this form to your servicemember's health care provider.

The Family and Medical Leave Act (FMLA) permits an employer to require that employees submit a timely, complete, and sufficient medical certification to support a request for FML to care for a covered servicemember. The completed form must be returned to HR-FMLA within 15 calendar days and may be faxed to HR-FMLA at 520-791-6514. Please do not send by email. Incomplete forms delay processing and will be returned to you for completion. Failure to provide a complete and sufficient certification may result in denial of your FML request.

Please refer to Pima County Administrative Procedure 23-37 for information and definitions.

Employee Name:_____ EIN:_____

Name of covered servicemember for whom you will provide care: (First Middle Last)

_____ Date of Birth: (mo/day/yr)_____

Relationship of servicemember to you:_____

Servicemember is a member or veteran of: ☐ Regular Armed Forces ☐ A Reserve component of the Armed Forces

Provide the covered servicemember's military branch, rank and current unit.

_____

1. 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)? ☐ No ☐ Yes
   If yes, provide the name of the medical treatment facility or unit.

   _____

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

3. Is the covered servicemember a covered veteran who is undergoing medical treatment, recuperation, or therapy for a serious injury or illness? ☐ No ☐ Yes

   If yes, Date of Discharge _____ (mo/day/yr) Date treatment commenced_____ (mo/day/yr)

4. Describe the care to be provided to the covered servicemember and provide an estimate of the amount of leave needed to provide the care.

_____ _____

Employee Signature Date

SECTION III: TO BE COMPLETED BY THE HEALTH CARE PROVIDER WHO IS:

- United States Department of Defense (DOD) health care provider
- DOD TRICARE network authorized private health care provider
- DOD Non-network TRICARE authorized private health care provider
- United States Department of Veterans Affairs (VA) health care provider

Please ensure that Section II has been completed before completing this section.

INSTRUCTIONS TO THE HEALTH CARE PROVIDER: The employee listed on page 1 has requested leave under the FMLA to care a Covered Servicemember. The servicemember is listed below. Answer all applicable parts of pages 2 through 4 completely and legibly. Several questions seek a response as to the frequency or duration of a condition, treatment, etc. Your answers should be your best estimate based upon your medical knowledge, experience, and examination of the patient. Limit your responses to the condition(s) for which the employee is seeking leave. Be as specific as you can. Terms such as "lifetime," "unknown," or "indeterminate" may not be sufficient to determine FMLA coverage. Incomplete or unsigned forms will be returned to the health care provider for completion and/or correction. *If you have any questions regarding completion of this form, contact HR-FMLA at 520-724-8076. The completed form may be faxed to HR-FMLA at 520-791-6514. Please do not send by email.*

Servicemember's Name: _____ Date of Birth: (mo/day/yr)_____

PART A: HEALTH CARE PROVIDER INFORMATION

Provider's Name:_____

Business Address:_____

_____

Type of practice / Medical specialty:_____

Phone:_____ Fax:_____

Email address: _____

Type of Health Care Provider: (check one)

- ☐ DOD TRICARE Network Authorized Private Health Care Provider
- ☐ DOD Non-network TRICARE Authorized Private Health Care Provider
- ☐ DOD Health Care Provider
- ☐ VA Health Care Provider

The Genetic Information Nondiscrimination Act of 2008 (GINA) prohibits employers and other entities covered by GINA Title II from requesting or requiring genetic information of an individual or family member of the individual, except as specifically allowed by this law. '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. **To comply with this law, we are asking that you do not provide any genetic information when responding to this request for medical information.**

Incomplete or unsigned forms will be returned to the health care provider for completion and/or correction.

_____

Signature of Health Care Provider Printed Name Date

The completed form may be faxed to HR-FMLA at 520-791-6514. Please do not send by email.

Pima County FMLA Medical Certification for Servicemember's Serious Health Condition

PART B: MEDICAL STATUS OF COVERED SERVICEMEMBER

Please note: If you are uncertain of the military-related determinations contained below, you are permitted to rely upon determinations from an authorized DOD representative (such as a DOD recovery care coordinator).

B-1. Covered servicemember's medical condition is classified as (check appropriate box):

- ☐ **(VSI) VERY SERIOUSLY ILL/INJURED** – Illness/Injury is of such 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.)
- ☐ **(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 healthcare providers.)
- ☐ **OTHER ILL/INJURED** – A serious injury or illness that may render the servicemember 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.)

B-2. Was the condition for which the covered servicemember is being treated incurred in the line of duty while on active duty in the Armed Forces? ☐ Yes ☐ No

B-3. Approximate date condition commenced: (mo/day/yr)_____

B-4. Probable duration of condition and/or need for care: _____

B-5. Is the covered servicemember undergoing medical treatment, recuperation, or therapy? ☐ Yes ☐ No
If yes, describe medical treatment, recuperation or therapy.

PART C: COVERED SERVICEMEMBER'S NEED FOR CARE BY FAMILY MEMBER

C-1. Will the covered servicemember need care for a single continuous period of time, including time for treatment and recovery? ☐ Yes ☐ No If yes, estimate the beginning and ending dates for this period of time.

From (start)_____ through (end)_____
mo/day/yr mo/day/yr

C-2. Will the covered servicemember require periodic follow-up treatment appointments? ☐ Yes ☐ No
If yes, estimate the treatment schedule.

C-3. Is there a medical necessity for the covered servicemember to have periodic care during or after these follow-up treatment appointments? ☐ Yes ☐ No

C-4. Is there a medical necessity for the covered servicemember to have periodic care for reasons other than scheduled follow-up treatment appointments (e.g., episodic flare-ups of medical condition)? ☐ Yes ☐ No
If yes, estimate the frequency and duration of the periodic care.