



Office of Congressional Workplace Rights

**Certification for Serious Injury or Illness of a Current Servicemember – for Military Family Leave (Family and Medical Leave Act, as made applicable by the Congressional Accountability Act)**

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**FORM F**

**Notice to the EMPLOYING OFFICE**

**INSTRUCTIONS to the EMPLOYING OFFICE:** The Family and Medical Leave Act (FMLA), as made applicable by the Congressional Accountability Act (CAA), provides that an employing office may require an employee seeking FMLA leave due to a serious injury or illness of a current servicemember to submit a certification providing sufficient facts to support the request for leave. Your response is voluntary. While you are not required to use this form, you may not ask the employee to provide more information than allowed under the FMLA regulations issued by the Office of Congressional Workplace Rights (OCWR) Board of Directors at 825.310. Employing offices must generally maintain records and documents relating to medical certifications, recertifications, or medical histories of employees or employees' family members created for FMLA purposes as confidential medical records in separate files/records from the usual personnel files, if the Americans with Disabilities Act and/or the Genetic Information Nondiscrimination Act apply, as made applicable by the CAA.

**SECTION I: For Completion by the EMPLOYEE and/or the CURRENT SERVICEMEMBER for whom the Employee is Requesting Leave**

**INSTRUCTIONS to the EMPLOYEE or CURRENT SERVICEMEMBER:** Please complete Section I before having Section II completed. The FMLA, as made applicable by the CAA, permits an employing office 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 servicemember. If requested by the employing office, your response is required to obtain or retain the benefit of FMLA-protected leave. Failure to do so may result in a denial of an employee's FMLA request. Board's regulations at 825.310(g) The employing office must give an employee at least 15 calendar days to return this form to the employing office.

**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; (3) a DOD non-network TRICARE authorized private health care provider; or (4) a health care provider as defined in the OOC regulations at 825.125.**

**INSTRUCTIONS to the HEALTH CARE PROVIDER: The employee listed on Page 2 has requested leave under the FMLA, as made applicable by the CAA, to care for a family member who is a current 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 in the Armed Forces or that existed before the beginning of the member’s active duty and was aggravated by service in the line of duty on active duty in the Armed Forces 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 servicemember’s injury or illness was incurred in the line of duty on active duty or if not, that the current servicemember’s injury or illness 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 that the current 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 servicemember’s condition for which the employee is seeking leave. Do not provide information about genetic tests, as defined in 29 C.F.R. §1635.3(f), or genetic services, as defined in 29 C.F.R. §1635.3(e).**

**The Genetic Information Nondiscrimination Act of 2008 (GINA) prohibits us from requesting/ requiring genetic information of an individual or family member of the individual, except as specifically allowed by GINA. We ask that you not provide any genetic information when responding to this request for medical information. “Genetic information” includes an individual’s family medical history, results of genetic tests, the fact that an individual or an individual/family member sought or received genetic services and genetic information of a fetus carried by an individual /family member/embryo lawfully held by an individual/family member receiving assistive reproductive services. (This section must be completed first before any of the below sections can be completed by a health care provider.)**

## **Part A: EMPLOYEE INFORMATION**

Name and Address of Employing Office (this is the employing office of the employee requesting leave to care for the current servicemember):

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Name of Employee Requesting Leave to Care for Current Servicemember:

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Name of the Current Servicemember (for whom employee is requesting leave to care):

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Relationship of Employee to the Current Servicemember:

Spouse Parent Son Daughter Next of Kin

**Part B: SERVICEMEMBER INFORMATION**

(1) Is the Servicemember a Current Member of the Regular Armed Forces, the National Guard or Reserves? Yes No

If yes, please provide the servicemember's military branch, rank and unit currently assigned to:

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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 medical hold or warrior transition unit)?

**SECTION I: For Completion by the EMPLOYEE and/or the CURRENT SERVICEMEMBER for whom the Employee Is Requesting Leave:**

Yes No

If yes, please provide the name of the medical treatment facility or unit:

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(2) Is the Servicemember on the Temporary Disability Retired List (TDRL)? Yes No

**Part C: CARE TO BE PROVIDED TO THE SERVICEMEMBER**

Describe the Care to Be Provided to the Current Servicemember and an Estimate of the Leave Needed to Provide the Care:

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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).

(Please ensure that Section I above has been completed before completing this section. Please be sure to sign the form on the last page.)

**Part A: HEALTH CARE PROVIDER INFORMATION**

Health Care Provider's Name and Business Address:

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Type of Practice/Medical Specialty:

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Please state whether you are either: (1) a DOD health care provider; (2) a 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 as defined in the OOC regulations at 825.125:

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Telephone: ( \_\_\_\_\_ ) \_\_\_\_\_ Fax: ( \_\_\_\_\_ ) \_\_\_\_\_

Email: \_\_\_\_\_

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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; (3) a DOD non-network TRICARE authorized private health care provider; or (4) a health care provider as defined in the OOC regulations at 825.125.**

**PART B: MEDICAL STATUS**

(1) The current 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 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, as made applicable by the CAA. If such leave is requested, you may be required to complete the OOC’s optional certification form (Form B) or an employing office-provided form seeking the same information.)**

(2) Is the current Servicemember being treated for a condition which was incurred or aggravated service in the line of duty on active duty in the Armed Forces? Yes No

(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 servicemember undergoing medical treatment, recuperation, or therapy for this condition? Yes No

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

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**PART C: SERVICEMEMBER’S NEED FOR CARE BY FAMILY MEMBER**

(1) Will the 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 servicemember require periodic follow-up treatment appointments? Yes No

**If yes, estimate the treatment schedule:**

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**(3) Is there a medical necessity for the servicemember to have periodic care for these follow-up treatment appointments? Yes No.**

**(4) 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:**

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**Signature of HealthCareProvider:** \_\_\_\_\_

**Date:** \_\_\_\_\_