



**Part C: 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**

**INSTRUCTIONS to the HEALTH CARE PROVIDER:** The employee listed above 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.

**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:

Provider’ Name: \_\_\_\_\_  
Business Address: \_\_\_\_\_  
Phone Number: \_\_\_\_\_

Type of Practice/Medical Specialty:

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Please check to indicate whether 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: \_\_\_\_\_

**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 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. If such leave is requested, you may be required to complete DOL FORM WH-380 or an employer-provided form seeking the same information.)

(2) Was the condition for which the Covered Service member is being treated incurred in 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 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:

\_\_\_\_\_

(2) Will the covered servicemember require periodic follow-up treatment appointments?

Yes  No

If yes, estimate the treatment schedule: \_\_\_\_\_

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

(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 forms to:**  
**MIT Disability Office**  
**77 Massachusetts Avenue, Bldg. E19-215**  
**Cambridge, MA 02139**  
**Confidential Fax: 617-253-1502**  
**Phone: 617-253-4572**  
**Email: [hr-dsmlo@mit.edu](mailto:hr-dsmlo@mit.edu)**