

If yes, please provide the covered servicemember's military branch, rank, 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 below:

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

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:

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).

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

Part A: Healthcare Provider Information

Health Care Provider's name and business address:

Type of Practice/medical specialty: _____

Please state whether you are either: (1) a DOD healthcare provider; (2) a VA health care provider; (3) a DOD TRICARE network authorized private health care provider; or (4) a DOD non-network TRICARE authorized private healthcare provider: _____

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

Part B: Medical Status

(1) Covered Servicemember's medical condition is classified as (check one):

(VSI) Very Seriously Ill/Injured – Illness/Injury is of such a severity that life is imminently endangered. Family members are requested at bedside. (Please note this is an internal DOD casualty assistance designation used by DOD healthcare providers.)

(SI) Seriously Ill/Injured – Illness/injury is of such a 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 the FMLA. If such leave is requested contact Human Resource Services to obtain correct form.)

(2) Was the condition for which the covered servicemember is being treated incurred 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 covered servicemember undergoing medical treatment, recuperation, or therapy? Yes No

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

Part C: Covered Servicemember's need for care by a 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: _____

Signature of Health Care Provider

Date