

**THE SCHOOL BOARD OF BROWARD COUNTY, FLORIDA
CERTIFICATION FOR SERIOUS INJURY OR ILLNESS
OF CURRENT SERVICEMEMBER
FOR MILITARY FAMILY LEAVE
(FAMILY AND MEDICAL LEAVE ACT)**



SECTION I: For completion by the EMPLOYEE and/or the CURRENT SERVICEMEMBER for whom the employee is requesting leave: (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 Employer (this is the employer of the employee requesting leave to care for current servicemember):

**The School Board of Broward County, Florida
Leaves Department
7770 W. Oakland Park Blvd.
Sunrise, FL 33351**

Name of Employee Requesting Leave to Care for Current Servicemember

Personnel Number

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

Relationship of Employee to Current Servicemember:

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

Part B: CURRENT SERVICEMEMBER INFORMATION

1. Is the Current Servicemember a current member of the Regular Armed Forces, the National Guard or Reserves?
Yes ____ No ____

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

Is the current 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:

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

Part C: CARE TO BE PROVIDED TO THE CURRENT SERVICEMEMBER

Describe the care to be provided to the current 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 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: _____

Telephone: _____ Fax: _____ Email: _____

Type of Practice/Medical Specialty: _____

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; or (4) a DOD non-network TRICARE authorized private health care provider: _____

Part B: MEDICAL STATUS

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

2. Was the condition for which the Current Service member is being treated incurred in 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 current servicemember undergoing medical treatment, recuperation, or therapy? Yes ____ No ____
If yes, please describe medical treatment, recuperation or therapy: _____

Part C: CURRENT SERVICEMEMBER'S NEED FOR CARE BY FAMILY MEMBER

1. Will the current 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 current servicemember require periodic follow-up treatment appointments? Yes ____ No ____

If yes, estimate the treatment schedule: _____

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

4. Is there a medical necessity for the current 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:** _____