

Highland Park Independent School District

Certification of Serious Injury or Illness of Covered Servicemember

SECTION I: For Completion by the EMPLOYER of the Employee Requesting Leave to Care for Covered Servicemember:

Employer Name: Highland Park Independent School District

Employer Address: Highland Park ISD Personnel Department, 7015 Westchester Drive, Dallas, Texas 75205

Employer Contact: Melinda Tubb, Personnel Specialist

Telephone: 214-781-3012 Fax: 214-780-3099

SECTION II: For Completion by the EMPLOYEE and/or COVERED SERVICEMEMBER for Whom the Employee is Requesting Leave to Provide Care:

INSTRUCTIONS to the EMPLOYEE or COVERED SERVICEMEMBER: Please complete Section II before having Section III completed. The Family and Medical Leave Act ("FMLA") permits Highland Park ISD to require that you submit a timely, complete, and sufficient certification to support your request for FMLA leave due to a covered servicemember's serious injury or illness. Your response is required to obtain or retain the benefit of FMLA-protected leave. If you do not provide a complete and sufficient certification by _____, which is at least 15 days from your receipt of this form, Highland Park ISD will delay or deny the leave, continued leave, or restoration to employment, treat your absence as unexcused, and impose appropriate disciplinary action, up to and including termination of employment. **Please sign and date the form on page 2.**

PART A: EMPLOYEE INFORMATION

Employee Name: _____
First Middle Last

Name of covered servicemember (for whom employee is requesting leave to care):

First Middle Last

Relationship of employee to covered servicemember requesting leave to care:

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

Do you (or a family member of the covered servicemember) have invitational travel orders ("ITOs") or invitational travel authorizations ("ITAs")? ____ Yes ____ No

If yes, please attach a copy of the ITOs or ITAs. You may submit a copy of the ITOs or ITAs in lieu of completing the remainder of this form. If authenticated by Highland Park ISD, you will not be required to provide any additional or separate certification unless you need leave to care for a covered servicemember beyond the expiration date specified in the ITOs or ITAs. If you will need leave to care for a covered servicemember beyond that expiration date, you must submit a fully completed form for the remainder of the leave period that you request.

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PART B: COVERED SERVICEMEMBER INFORMATION

- (1) Is the covered servicemember a current member of the Armed Forces, including the National Guard or Reserves? ____ Yes ____ No

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

Is the covered servicemember assigned to a military medical treatment facility as an outpatient or 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 covered servicemember on the Temporary Disability Retired List (TDRL)? ____ Yes ____ No

PART C: CARE TO BE PROVIDED TO THE COVERED SERVICEMEMBER

Describe the care you will provide to the covered servicemember: _____

Requested leave dates (best estimate):

- ☐ I will need a continuous block of leave from: _____ to: _____
- ☐ I will need a reduced-schedule leave from: _____ to: _____
- ☐ I will need intermittent leave from: _____ to: _____

PART D: ACKNOWLEDGEMENT / SIGNATURE

I understand that if I do not timely submit a complete and sufficient certification, Highland Park ISD will delay or deny the leave, continued leave, or restoration to employment, treat my absence as unexcused, and impose appropriate disciplinary action, up to and including termination of employment. I further understand that if I make any false or misleading oral or written statement in connection with my request for leave, I will be subject to appropriate disciplinary action, up to and including termination of employment. I certify that all statements in Section II of this form are true and complete.

Signature of Employee

Date

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SECTION III: For Completion by a U.S. Department of Defense (“DOD”) Health Care Provider or a Health Care Provider who is either (1) a U.S. 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: Please ensure that Section II above has been completed before completing this section. 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).

The employee listed on Page 1 has requested leave under the FMLA to care for a family member who is:

- (1) a current member of the Armed Forces (including the National Guard or Reserves) with a serious injury or illness incurred in the line of duty on active duty or aggravated by such service; or
- (2) a veteran of the Armed Forces (including the National Guard or Reserves) with a serious injury or illness incurred in the line of duty on active duty or aggravated by such services, regardless of when manifested, and who was a member of the Armed Forces, National Guard, or Reserves at any time during the 5-year period before the need for the leave arose.

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 or aggravated 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 below. Please answer all applicable parts fully and completely. Several questions seek a response as to the frequency or duration of a condition or treatment. You should provide the best estimate based on your medical knowledge, experience, and examination of the patient. Please be as specific as possible; terms such as “lifetime,” “unknown,” or “indeterminate” may not be sufficient to determine FMLA coverage.

You should limit your responses to the patient’s condition for which the employee seeks leave to provide care. Please do not provide any information about the patient’s family medical history or genetic information.

Please sign and date the form on the last page.

PART A: HEALTHCARE PROVIDER INFORMATION

Name of Health Care Provider: _____

Business Address: _____

Type of Practice/Medical Specialty: _____

Telephone (with area code): _____ Fax: _____

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I am a (check one of the appropriate boxes):

- ☐ DOD health care provider.
- ☐ VA health care provider.
- ☐ DOD TRICARE network authorized private health care provider.
- ☐ DOD non-network TRICARE authorized private health care provider.

PART B: MEDICAL STATUS

(1) The covered servicemember's medical condition is classified as (check one box):

- ☐ **(VSI) Very Seriously Ill/Injured** — Illness/Injury is of such a severity that life is imminently endangered. Family members are requested at bedside immediately.
- ☐ **(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.
- ☐ **Other Ill/Injured** — a serious injury or illness that was incurred in the line of active duty or aggravated by such service and:
 - (a) for a current member of the Armed Forces (including the National Guard or Reserves) may render the member medically unfit to perform the duties of the member's office, grade, rank, or rating; or
 - (b) for a veteran of the Armed Forces (including the National Guard or Reserves) is a qualifying (as defined by the Secretary of Labor) injury or illness that manifested itself before or after the member became a veteran.
- ☐ **None of the Above** (Note to Employee: If this box is checked, you still may be eligible to take leave to care for a covered family member with a "serious health condition." If you request such leave, Highland Park ISD will require you to complete an appropriate medical certification 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) If the answer to the preceding question is "No," was the condition aggravated by service in the line of duty on active duty in the Armed Forces? ____ Yes ____ No

(4) Approximate date condition commenced: _____

(5) Probable duration of condition and/or need for care: _____

(6) 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 ANOTHER

- (1) Will the covered servicemember need physical or psychological care from the employee or another person 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: _____ to _____

- (2) Will the covered servicemember require periodic follow-up treatment appointments? ____ Yes ____ No

If yes, is there a medical necessity for the covered servicemember to have periodic care from the employee or another person for these follow-up treatment appointments? ____ Yes ____ No

If yes, estimate the frequency and duration of the treatment schedule: _____ to _____

Frequency: _____

- (3) Is there a medical necessity for the covered servicemember to have periodic care from the employee or another person, other than for 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: _____ to _____

Frequency: _____

Signature of Healthcare Provider

Date

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