NALC Form 4 Family and Medical Leave Act Form

Employee: Return the completed form to the appropriate FMLA administration HRSSC address or fax (see attached sheet) and keep a copy for your own records.

Certification for Serious Injury or Illness* of Current Covered Servicemember for Military Caregiver Leave

Section 1: For completion by the employee and/or the covered servicemember for whom the employee is requesting leave.

A. Name (First, Middle, and Last) of the employee requesting leave to care for covered servicemember:

_____

EIN: _____ FMLA Case # (if known): _____

B. Name (First, Middle, and Last) of covered sevicemember (for whom employee is requesting leave to care for):

_____

C. Relationship of covered servicemember to employee:
❒ Spouse ❒ Parent ❒ Son ❒ Daughter ❒ Next of Kin

D. Has an ITO (Invitational Travel Order) or ITA (Invitational Travel Authorization) been issued to a family member of the covered servicemember (the employee need not be the family member named)? ❒ Yes ❒ No

If yes, the period of time specified in the ITO or ITA: from _____ to _____

If the requested leave to care for the covered servicemember falls within the time period specified on the ITO or ITA, present a copy of the ITO or ITA to the appropriate Postal Service Supervisor. No further certification is required. However, in order for the employee to take military caregiver leave outside the period indicated on the ITO or ITA, the rest of this form must be completed.

E. Is the covered servicemember a current member of the Regular Armed Forces, the National Guard or Reserves?
❒ Yes ❒ No

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

_____

F. Is the covered servicemember assigned to 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:

_____

G. Is the covered servicemember on the Temporary Disability Retired List (TDRL)? ❒ Yes ❒ No

H. Describe the care to be provided to the covered servicemember and an estimate of the leave needed to provide the care:

_____

_____

*SERIOUS INJURY OR ILLNESS.—The term 'serious injury or illness' means an injury or illness that was incurred by the covered servicemember in the line of duty on active duty in the Armed Forces (or existed before the beginning of the covered servicemember's active duty and was aggravated by service in the line of duty on active duty in the Armed Forces) and that may render the covered servicemember medically unfit to perform the duties of his or her office, grade, rank, or rating.

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Section 2: For completion by 1) a United States Department of Defense ("DOD") health care provider or health care provider who is either: 2) a United States Department of Veterans Affairs ("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 under the FMLA (as defined in 29 CFR 825.125). Please be sure to sign the form in the place provided at the end.

A. Health care provider information

Health care provider's name (please print): _____

Health care provider's business address: _____

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

Type of practice/medical specialty: _____

Please indicate whether you are: ❒ 1. a DOD health care provider ❒ 2. a VA health care provider
❒ 3. a DOD TRICARE network authorized provider ❒ 4. a DOD non-network TRICARE authorized healthcare provider
❒ 5. a health care provider under the FMLA

B. Medical status

If you are unable to make certain of the military-related determinations contained in Part B below, you are permitted to rely upon determinations from an authorized DOD representative (such as a DOD recovery care coordinator) or an authorized VA representative.

1) Was the covered servicemember's injury or illness incurred or aggravated in the line of duty on active duty? ❒ Yes ❒ No

2) Approximate date the serious injury or illness commenced or was aggravated: _____

3) Probable duration of the serious injury or illness and/or need of care: _____

4) Briefly state the medical facts regarding the covered servicemember's health condition for which FMLA leave is requested:

_____

_____

5) Does the injury or illness render the covered service member medically unfit to perform the duties of his or her office, grade, rank or rating? ❒ Yes ❒ No

6) Is the covered servicemember undergoing medical treatment, recuperation, or therapy? ❒ Yes ❒ No. If yes, please describe medical treatment, recuperation or therapy:

_____

_____

C. Covered servicemember's need for care by family member

1) Does the patient require assistance for basic medical, hygiene, nutritional needs, safety, transportation? ❒ Yes ❒ No

2) If no, would the employee's presence to provide psychological comfort be beneficial to the patient or assist in the patient's recovery? ❒ Yes ❒ No

3) 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: _____

4) Will the covered servicemember require periodic follow-up treatment appointments? ❒ Yes ❒ No.
If yes, estimate the treatment schedule: _____

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

6) 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 (e.g.: 2 times per week for 8 months lasting 1 day):

Frequency: _____ times per _____ week(s) _____ month(s)
Duration: _____ hour(s) or _____ day(s) per event.

Signature of health care provider: _____ Date: _____