Human Resources
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CERTIFICATION FOR SERIOUS INJURY/ILLNESS OF SERVICEMEMBER

PART A: FOR COMPLETION BY THE EMPLOYEE

1. Employee Name: _____ 2. PLU ID#: _____

3. Servicemember Name: _____ 4. Relationship to Employee: _____

5. 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:

_____

6. Is covered servicemember on the Temporary Disability Retired List (TDRL)? [ ] YES [ ] NO

7. I shall personally provide care for my family member as described herein which will take the noted amount of time. If leave is to be taken intermittently or on a reduced leave schedule, I have provided a schedule of time I will be away from work and a reduced leave schedule as appropriate. (Additional pages may be attached as necessary):

Signature: _____ Date: _____

PART B: TO BE COMPLETED BY HEALTH CARE PROVIDER

8. Covered servicemember's medical condition is classified as (check one of the appropriate boxes):
   - [ ] 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.)
   - [ ] 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.")
9. 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
10. Date condition commenced: _____ 11. Probable duration of condition and/or need for care: _____
12. Is the covered servicemember undergoing medical treatment, recuperation, or therapy? [ ] YES [ ] NO
If yes, please describe medical treatment, recuperation or therapy:

13. 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: _____
14. Will the covered servicemember require periodic follow-up treatment appointments?
[ ] YES [ ] NO If yes, estimate the treatment schedule:

15. Is there a medical necessity for the covered servicemember to have periodic care for follow-up treatment appointments or other care (e.g., episodic flare-ups of medical condition)?
[ ] YES [ ] NO If yes, please estimate the frequency and durations of the periodic care:

16. Signature of Health Care Provider: _____ Date: _____

Typed/Printed Name of Health Care Provider:

Address & Phone Number:

Health Care Provider's Field of Specialization: