TRISTAR®

CERTIFICATION FOR SERIOUS INJURY OR ILLNESS OF A VETERAN FOR MILITARY CAREGIVER LEAVE (Family and Medical Leave Act)

Employee Name:		
Home Address:		
Home Telephone:	Cell Phone:	Other phone:
Employer Name:	Last Day Worked:	First Day Missed:

COMPLETE THE FOLLOWING STEPS:
STEP 1: Verify and complete all of the information above.
STEP 2: Give all pages to your Veteran's Health Care Provider and instruct them to complete.
After the Health Care Provider has completed and signed the bottom,

- **fax the form to TRISTAR at 562/495-6687**
- **email the form to ICSFax@tristargroup.net**
- **mail to TRISTAR, 2835 Temple Avenue, Signal Hill, CA 90755**

TRISTAR only needs one copy of this form, so please choose one method of delivery only.

INSTRUCTIONS to the EMPLOYEE and/or the VETERAN:
The FMLA allows an employer to require that an employee submit a timely, complete, and sufficient certification to support a request for military caregiver leave under the FMLA due to a serious injury or illness of a covered veteran. If requested by the employer, your response is required to obtain or retain the benefit of FMLA-protected leave. The employer must give an employee **at least 15 calendar days** to return this form to the employer. 29 U.S.C. §§ 2613, 2614(c)(3).

PART A: EMPLOYEE INFORMATION

(1) Name of Veteran (for whom employee is requesting leave):

_____
First Middle Last

(2) Select your relationship to the veteran. You are the veteran's:
☐ Spouse ☐ Parent ☐ Child ☐ Next of Kin

Spouse means a husband or wife as defined or recognized in the state where the individual was married, including a common law marriage or same-sex marriage. The terms "child" and "parent" include in loco parentis in which a person assumes the obligations of a parent to a child. An employee may take FMLA leave to care for a covered servicemember who assumed the obligations of a parent to the employee when the employee was a child. An employee may also take FMLA leave to care for a covered servicemember for whom the employee has assumed the obligations of a parent. No biological or legal relationship is necessary. "Next of kin" is the veteran's nearest blood relative, other than the spouse, parent, son, or daughter, in the following order of priority: (1) a blood relative as designated in writing by the veteran for purposes of FMLA leave, (2) blood relatives granted legal custody of the veteran, (3) brothers and sisters, (4)grandparents, (5) aunts and uncles, and (6) first cousins.

PART B: VETERAN INFORMATION AND CARE TO BE PROVIDED TO THE VETERAN

(3) The veteran was (☐ honorably / ☐ dishonorably) discharged or released from the Armed Forces, including the National Guard or Reserves. List the date of the veteran's discharge: _____ (mm/dd/yyyy)

(4) Please provide the veteran's military branch, rank and unit at the time of discharge:

_____

(5) The veteran (☐ is / ☐ is not) receiving medical treatment, recuperation, or therapy for an injury or illness.

(6) Briefly describe the care you will provide to the veteran: (*Check all that apply*)
☐ Assistance with basic medical, hygienic, nutritional, or safety needs
☐ Psychological Comfort ☐ Physical Care
☐ Transportation ☐ Other: _____

Employee Name:_____ Employer:_____

(7) Give your **best estimate** of the amount of FMLA leave needed to provide the care described:

_____

(8) If a **reduced work schedule** is necessary to provide the care described, give your **best estimate** of the reduced schedule you are able to work. From _____ *(mm/dd/yyyy)* to _____ *(mm/dd/yyyy),* I am able to work _____ (*hours per day*) _____ (*days per week).*

INSTRUCTIONS to the HEALTH CARE PROVIDER

Please provide your contact information, complete all Parts of this Section fully and completely, and sign the form below. The employee named in Section I has requested leave under the military caregiver leave provision of the FMLA to care for a family member who is a veteran.

Note: For purposes of FMLA military caregiver leave, a serious injury or illness means an injury or illness incurred by the servicemember in the line of duty on active duty in the Armed Forces (or that existed before the beginning of the servicemember's active duty and was aggravated by service in the line of duty on active duty in the Armed Forces) and manifested itself before or after the servicemember became a veteran, and is: a continuation of a serious injury or illness that was incurred or aggravated when the covered veteran was a member of the Armed Forces and rendered the servicemember unable to perform the duties of the servicemember's office, grade, rank, or rating; or a physical or mental condition for which the covered veteran has received a U.S. Department of Veterans Affairs Service Related Disability Rating (VASRD) of 50 percent or greater, and such VASRD rating is based, in whole or in part, on the condition precipitating the need for military caregiver leave; or a physical or mental condition that substantially impairs the covered veteran's ability to secure or follow a substantially gainful occupation by reason of a disability or disabilities related to military service, or would do so absent treatment; or an injury, including a psychological injury, on the basis of which the covered veteran has been enrolled in the Department of Veterans' Affairs Program of Comprehensive Assistance for Family Caregivers.

"Need for care" includes both physical and psychological care. It includes situations where, for example, due to his or her serious injury or illness, the veteran is not able to care for his or her own basic medical, hygienic, or nutritional needs or safety, or needs transportation to the doctor. It also includes providing psychological comfort and reassurance which would be beneficial to the veteran who is receiving inpatient or home care.

A complete and sufficient certification to support a request for FMLA military caregiver leave due to a covered veteran's serious injury or illness includes written documentation confirming that the veteran's injury or illness was incurred in the line of duty on active duty or existed before the beginning of the veteran's active duty and was aggravated by service in the line of duty on active duty, and that the veteran is undergoing treatment, recuperation, or therapy for such injury or illness by a health care provider listed above. Information about the FMLA may be found on the WHD website at www.dol.gov/agencies/whd/fmla.

Please be sure to sign the form on the last page and return all three (3) pages to TRISTAR as instructed above.

PART A: HEALTH CARE PROVIDER INFORMATION

Health Care Provider's name: _____

Health Care Provider's business address: _____

Type of Practice / Medical specialty: _____

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

Please select the type of FMLA health care provider you are:

- ☐ 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
- ☐ Health care provider as defined in 29 C.F.R. § 825.125

PART B: MEDICAL INFORMATION

Please provide appropriate medical information of the patient as requested below. Limit your responses to the veteran's condition for which the employee is seeking leave. If you are unable to make certain military-related determinations contained 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. Do not provide information about genetic tests, as defined in 29 C.F.R. § 1635.3(f), or genetic services, as defined in 29 C.F.R. § 1635.3(e).

Employee Name:_____ Employer:_____

(1) Patient's Name: _____

(2) List the approximate date condition started or will start: _____*(mm/dd/yyyy*)

(3) Provide your **best estimate** of how long the condition will last: _____

(4) The veteran's injury or illness: (*Select as appropriate*)

☐ Was incurred in the line of duty on active duty.

☐ Existed before the beginning of the veteran's active duty and was aggravated by service in the line of duty on active duty.

☐ None of the above.

The veteran (☐ is / ☐ is not) undergoing medical treatment, recuperation, or therapy for this condition.
If yes, briefly describe the medical treatment, recuperation or therapy: _____
_____

(5) The veteran's medical condition is: (*Select as appropriate*)

☐ A continuation of a serious injury or illness that was incurred or aggravated when the covered veteran was a member of the Armed Forces and rendered the servicemember unable to perform the duties of the servicemember's office, grade, rank, or rating.

☐ A physical or mental condition for which the covered veteran has received a U.S. Department of Veterans Affairs Service Related Disability Rating (VASRD) of 50% or higher, and such VASRD rating is based, in whole or in part, on the condition precipitating the need for military caregiver leave.

☐ A physical or mental condition that substantially impairs the covered veteran's ability to secure or follow a substantially gainful occupation by reason of a disability or disabilities related to military service, or would do so absent treatment.

☐ An injury, including a psychological injury, on the basis of which the covered veteran is enrolled in the Department of Veterans' Affairs Program of Comprehensive Assistance for Family Caregivers.

☐ None of the above. *Note to Employee: If this box is checked, you may still be eligible to take leave to care for a coveredfamily member with a "serious health condition" under 29 C.F.R. § 825.113 of the FMLA. If such leave is requested, youmay be required to complete DOL FORM WH-380-F or an employer-provided form seeking the same information.*

PART C: AMOUNT OF LEAVE NEEDED

For the medical condition checked in Part B, complete all that apply. Some questions seek a response as to the frequency or duration of a condition, treatment, etc. Your answer should be your best estimate based upon your medical knowledge, experience, and examination of the patient. Be as specific as you can; terms such as "lifetime," "unknown," or "indeterminate" may not be sufficient to determine FMLA military caregiver leave coverage.

(1) Due to the condition, the veteran will need care for a **continuous period of time**, including any time for treatment and recovery. Provide your **best estimate** of the beginning date _____ (*mm/dd/yyyy*) and end date _____ (*mm/dd/yyyy*) for this period of time.

(2) Due to the condition, it is medically necessary for the veteran to attend **planned medical treatment** appointments (scheduled medical visits). Provide your **best estimate** of the duration of the treatment(s), including any period(s) of recovery _____ (*e.g. 3 days/week)*

(3) Due to the condition, it is medically necessary for the veteran to receive care on an **intermittent basis** (periodically), such as the care needed because of episodic flare-ups of the condition or assisting with the veteran's recovery. Provide your **best estimate** of how often (frequency) and how long (the duration) the intermittent episodes will likely last.

Over the next 6 months, intermittent care is estimated to occur _____ times per (☐ day / ☐ week / ☐ month) and are likely to last approximately _____ (☐ hours / ☐ days) per episode.

_____ _____
Signature of Health Care Provider **Date**

PAPERWORK REDUCTION ACT NOTICE AND PUBLIC BURDEN STATEMENT

If submitted, it is mandatory for employers to retain a copy of this disclosure in their records for three years, in accordance with 29 U.S.C. 2616; 29 CFR 825.500. Persons are not required to respond to this collection of information unless it displays a currently valid OMB control number. The Department of Labor estimates that it will take an average of 20 minutes for respondents to complete this collection of information, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. If you have any comments regarding this burden estimate or any other aspect of this collection information, including suggestions for reducing this burden, send them to the Administrator, Wage and Hour Division, U.S. Department of Labor, Room S-3502, 200 Constitution Ave., NW, Washington, DC 20210.

DO NOT SEND THE COMPLETED FORM TO THE DEPARTMENT OF LABOR
Please return the form to TRISTAR as instructed on page 1.