University of New Hampshire

Military Family Health Certification - Form C

SECTION 1: TO BE COMPLETED BY EMPLOYEE

Information on this form is confidential and private and will be shared strictly on a need to know basis. This form is used for employee family caregiver leaves including those covered by the Family and Medical Leave Act (FMLA).

_____ ____/____/____

Name (Last, First, MI) SS# (Last 4 Digits) Date

_____

Name of Service Member or Veteran (Last, First, MI) ☐Spouse ☐Parent☐ Son ☐ Daughter☐Next of Kin

If Next of Kin specify relationship_____

Service Member Information	**Veteran Information**
Is the Service Member a current member of the Armed Forces, the National Guard or Reserves? No ☐ Yes☐ If yes, please provide the following: Military Branch _____ Rank _____ Unit _____ Is the Service Member 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)? No☐Yes ☐ If so, please provide the name of the medical treatment facility or unit _____	Was Veteran dishonorably discharge or released from the Armed Forces, National Guard or Reserves? No ☐ Yes☐ At the time of discharge please provide the following: Military Branch _____ Rank _____ Unit _____ Date of Discharge ____/____/____

Is the Service Member/Veteran on the Temporary Disability Retired List (TDRL)? No ☐ Yes ☐

Describe the care to be provided to the current Service Member/Veteran and an estimate of the leave time needed to provide the care _____

_____

SECTION 2: TO BE COMPLETED BY HEALTH PROVIDER

_____

Print Name Phone Fax

_____

Business Address (street, city, state, zip)

Type of Practice/Medical Specialty_____

Indicate health care type: ☐DOD ☐VA ☐DOD TRICARE network ☐DOD TRICARE non-network ☐Other

Be as specific as you can; terms such as "lifetime," "unknown," or "indeterminate" may not be sufficient to determine FMLA coverage. Limit your responses to the service member's/veteran's condition for which the employee is seeking leave. Do not provide information about genetic tests, as defined in 29 CFR 1635.3(f), or genetic services, as defined in 29 CFR 1635.3(e). If you are unable to make

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certain of the military-related determination below, you are permitted to rely upon determinations from an authorized DOD representative (such as a DOD recovery care coordinator)

Service Member's medical condition is classified as

☐Very Seriously Ill/Injured – is such of a severity that life is imminently endangered family members are requested to bedside

☐Seriously Ill/Injured – is such of severity that there is cause for immediate concern, but there is no imminent danger to life family members are requested to bedside

☐Other Ill/Injured – that may render the service member medically unfit to perform the duties of the member's office, grade, rank, or rating

☐None of the above

Veteran's medical condition is

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

☐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

Is the service member/veteran being treated for a condition which was aggravated by service in the line of duty on active duty in the Armed Forces? No☐ Yes☐ Approximate date condition commenced ____/____/____

Probable duration of the condition and/or need for care _____
(# of weeks/months/days)

Probable duration of the patient's present incapacity if different _____
(# of days, weeks, months)

Is the service member/veteran undergoing medical treatment, recuperation, or therapy for this condition? No☐ Yes☐ If so, describe the medical treatment, recuperation or therapy _____
_____

Will the service member/veteran need care for a single continuous period of time, including any time for treatment and recovery? No ☐ Yes☐ If so, estimate the beginning and ending dates for this period of time ____/____/____ through ____/____/____

Will the service member/veteran require periodic follow-up treatment appointments No ☐ Yes☐
If so, estimate the treatment schedule _____

Is there a medical necessity for the service member/veteran to have periodic care for these follow-up treatment appointments? No ☐ Yes☐

Is there a medical necessity for the service member/veteran to have periodic care other than scheduled follow-up treatment appointments (e.g. episodic flare-ups of medical condition) No ☐ Yes☐ If so, please estimate the frequency and duration of the periodic care _____

Provider's Signature

Providers Name: _____
Address: _____
Phone: _____
Signature: _____
Date: _____/_____/_____

Fax or mail completed form to:
UNH Human Resources
2 Leavitt Lane
Durham, NH 03824
Fax# 603-862-5159