CERTIFICATION FOR SERIOUS INJURY OR ILLNESS OF COVERED SERVICEMEMBER FOR MILITARY FAMILY LEAVE (FAMILY AND MEDICAL LEAVE ACT)

OMB Control Number: 1215-0181
Form WH-385 November 2008

Notice to the EMPLOYER

INSTRUCTIONS to the EMPLOYER: The Family and Medical Leave Act (FMLA) provides that an employer may require an employee seeking FMLA leave due to a serious injury or illness of a covered service member to submit a certification providing sufficient facts to support the request for leave. Your response is voluntary. While you are not required to use this form, you may not ask the employee to provide more information than allowed under the FMLA regulations, 29 C.F.R. § 825.310. Employers must generally maintain records and documents relating to medical certifications, recertifications, or medical histories of employees or employees' family members, created for FMLA purposes as confidential medical records in separate files/records from the usual personnel files and in accordance with 29 C.F.R. § 1630.14(c)(1), if the Americans with Disabilities Act applies.

Section I: For Completion by the EMPLOYEE and/or the COVERED SERVICEMEMBER for whom the Employee is Requesting Leave

INSTRUCTIONS to the EMPLOYEE or COVERED SERVICEMEMBER: Please complete Section I before having Section II completed. The FMLA permits an employer to require that an employee submit a timely, complete, and sufficient certification to support a request for FMLA leave due to a serious injury or illness of a covered servicemember. If requested by the employer, your response is required to obtain or retain the benefit of FMLA-protected leave, 29 U.S.C. § 2613, 2612(c)(3). Failure to do so may result in a denial of an employee's FMLA request, 29 C.F.R. § 825.310(f). The employer must give an employee at least 15 calendar days to return this form to the employer.

Section II: For Completion by a UNITED STATES DEPARTMENT OF DEFENSE ("DOD") HEALTH CARE PROVIDER or a HEALTH CARE PROVIDER who is either: (1) a United States 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: The employee listed on Page 2 has requested leave under the FMLA to care for a family member who is a member of the Regular Armed Forces, the National Guard, or the Reserves who is undergoing medical treatment, recuperation, or therapy, is otherwise in outpatient status, or is otherwise on the temporary disability retired list for a serious injury or illness. For purposes of FMLA leave, a serious injury or illness is one that was incurred in the line of duty on active duty that may render the servicemember medically unfit to perform the duties of his or her office, grade, rank, or rating.

A complete and sufficient certification to support a request for FMLA due to a covered servicemember's serious injury or illness includes written documentation confirming that the covered servicemember's injury or illness was incurred 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 above. Answer, fully and completely, all applicable parts. Several 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 coverage. Limit your responses to the condition for which the employee is seeking leave.

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Section I: For Completion by the EMPLOYEE and/or the COVERED SERVICE-MEMBER for whom the Employee is Requesting Leave: (This section must be completed first before any of the below sections can be completed by a health care provider.)

Part A: EMPLOYEE INFORMATION

Name and Address of Employer (this is the employer of the employee requesting leave to care for a covered servicemember):

Anthony Independent School District 840 Sixth Street Anthony, Texas 79821

Contact: Fred Herrera (915)886-6502 or Karen Elmore (915) 886-6508

Name of Employee Requesting Leave to Care for Covered Servicemember:

_____

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

Part B: COVERED SERVICE-MEMBER INFORMATION

1. 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:

   _____

   Is the covered servicemember 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)? ❒ Yes ❒ No

   If yes, 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 to be Provided to the Covered Servicemember and an Estimate of the Leave Needed to Provide the

Care: _____

_____

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Section II: For Completion by a United States Department of Defense (DOD) Health Care Provider or a Health Care Provider who is either: (1) a United States 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. If you are unable to make certain of the military-related determinations contained below in Part B, you are permitted to rely upon determination from an authorized DOD representative (such as a DOD recovery care coordinator. (Please ensure that Section I above has been completed before completing this section.) Please be sure to sign the form on the last page.

Part A: HEALTH CARE PROVIDER INFORMATION

Health Care Provider's Name and Business Address: _____

_____

Type of Practice/Medical Specialty: _____

Please indicate whether 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

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

Part B: MEDICAL STATUS

1. Covered Service-Member's medical condition is classified as (Check one of the Appropriate Boxes):

   ❒ **(VSI) Very Seriously Ill/Injured—**Illness/Injury is of such 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 health care providers.)

   ❒ **(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 the bedside. (Please note this is an internal DOD casualty assistance designation used by DOD health care 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" under 29 C.F.R. § 825.113 of the FMLA. If such leave is requested, you may be required to complete DOL Form WH-380 or an employer-provided form seeking the same information.)

2. Was the condition for which the covered service-member is being treated incurred in the line of duty on active duty in the armed forces? ❒ Yes ❒ No

3. Approximate date condition commenced: _____

4. Probably duration of condition and/or need for care: _____

5. Is the covered service-member undergoing medical treatment, recuperation, or therapy? ❒ Yes ❒ No
   If yes, please describe medical treatment, recuperation, or therapy: _____

_____

Part C: COVERED SERVICEMEMBER'S NEED FOR CARE BY FAMILY MEMBER

1. Will the covered servicemember need care for a single continuous period of time, including any time for treatment or recovery? ❒ Yes ❒ No

   If yes, estimate the beginning and ending dates for this period of time: _____

   _____

2. Will the covered servicemember require periodic follow-up treatments appointments? ❒ Yes ❒ No

   If yes, estimate the treatment schedule: _____

   _____

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

4. 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: _____

   _____

_____ _____

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, 29 U.S.C. § 2616, 29 C.F.R. § 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 of 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 COMPLETED FORM TO THE DEPARTMENT OF LABOR; RETURN TO THE PATIENT.**