

EMPLOYEE RIGHTS UNDER THE FAMILY AND MEDICAL LEAVE ACT

THE UNITED STATES DEPARTMENT OF LABOR WAGE AND HOUR DIVISION

LEAVE ENTITLEMENTS



Eligible employees who work for a covered employer can take up to 12 weeks of unpaid, job-protected leave in a 12-month period for the following reasons:

- The birth of a child or placement of a child for adoption or foster care;
- To bond with a child (leave must be taken within one year of the child's birth or placement);
- To care for the employee's spouse, child, or parent who has a qualifying serious health condition;
- For the employee's own qualifying serious health condition that makes the employee unable to perform the employee's job;
- For qualifying exigencies related to the foreign deployment of a military member who is the employee's spouse, child, or parent.

An eligible employee who is a covered servicemember's spouse, child, parent, or next of kin may also take up to 26 weeks of FMLA leave in a single 12-month period to care for the servicemember with a serious injury or illness.

An employee does not need to use leave in one block. When it is medically necessary or otherwise permitted, employees may take leave intermittently or on a reduced schedule.

Employees may choose, or an employer may require, use of accrued paid leave while taking FMLA leave. If an employee substitutes accrued paid leave for FMLA leave, the employee must comply with the employer's normal paid leave policies.

While employees are on FMLA leave, employers must continue health insurance coverage as if the employees were not on leave.

Upon return from FMLA leave, most employees must be restored to the same job or one nearly identical to it with equivalent pay, benefits, and other employment terms and conditions.

An employer may not interfere with an individual's FMLA rights or retaliate against someone for using or trying to use FMLA leave, opposing any practice made unlawful by the FMLA, or being involved in any proceeding under or related to the FMLA.

ELIGIBILITY REQUIREMENTS

An employee who works for a covered employer must meet three criteria in order to be eligible for FMLA leave. The employee must:

- Have worked for the employer for at least 12 months;
- Have at least 1,250 hours of service in the 12 months before taking leave;* and
- Work at a location where the employer has at least 50 employees within 75 miles of the employee's worksite.

*Special "hours of service" requirements apply to airline flight crew employees.

REQUESTING LEAVE

Generally, employees must give 30-days' advance notice of the need for FMLA leave. If it is not possible to give 30-days' notice, an employee must notify the employer as soon as possible and, generally, follow the employer's usual procedures.

Employees do not have to share a medical diagnosis, but must provide enough information to the employer so it can determine if the leave qualifies for FMLA protection. Sufficient information could include informing an employer that the employee is or will be unable to perform his or her job functions, that a family member cannot perform daily activities, or that hospitalization or continuing medical treatment is necessary. Employees must inform the employer if the need for leave is for a reason for which FMLA leave was previously taken or certified.

Employers can require a certification or periodic recertification supporting the need for leave. If the employer determines that the certification is incomplete, it must provide a written notice indicating what additional information is required.

EMPLOYER RESPONSIBILITIES

Once an employer becomes aware that an employee's need for leave is for a reason that may qualify under the FMLA, the employer must notify the employee if he or she is eligible for FMLA leave and, if eligible, must also provide a notice of rights and responsibilities under the FMLA. If the employee is not eligible, the employer must provide a reason for ineligibility.

Employers must notify its employees if leave will be designated as FMLA leave, and if so, how much leave will be designated as FMLA leave.

ENFORCEMENT

Employees may file a complaint with the U.S. Department of Labor, Wage and Hour Division, or may bring a private lawsuit against an employer.

The FMLA does not affect any federal or state law prohibiting discrimination or supersede any state or local law or collective bargaining agreement that provides greater family or medical leave rights.



For additional information or to file a complaint:

1-866-4-USWAGE

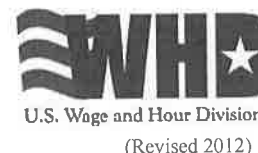
(1-866-487-9243) TTY: 1-877-889-5627

www.dol.gov/whd

U.S. Department of Labor | Wage and Hour Division



U.S. Department of Labor
Wage and Hour Division



Fact Sheet #28: The Family and Medical Leave Act

The Family and Medical Leave Act (FMLA) entitles eligible employees of covered employers to take unpaid, job-protected leave for specified family and medical reasons. This fact sheet provides general information about which employers are covered by the FMLA, when employees are eligible and entitled to take FMLA leave, and what rules apply when employees take FMLA leave.

COVERED EMPLOYERS

The FMLA only applies to employers that meet certain criteria. A **covered employer** is a:

- Private-sector employer, with 50 or more employees in 20 or more workweeks in the current or preceding calendar year, including a joint employer or successor in interest to a covered employer;
- Public agency, including a local, state, or Federal government agency, regardless of the number of employees it employs; or
- Public or private elementary or secondary school, regardless of the number of employees it employs.

ELIGIBLE EMPLOYEES

Only eligible employees are entitled to take FMLA leave. An **eligible employee** is one who:

- Works for a *covered employer*;
- Has worked for the employer for at least *12 months*;
- Has at least *1,250 hours* of service for the employer during the 12 month period immediately preceding the leave*; and
- Works at a location where the employer has at least *50 employees within 75 miles*.

* Special hours of service eligibility requirements apply to airline flight crew employees. See Fact Sheet 28J: Special Rules for Airline Flight Crew Employees under the Family and Medical Leave Act.

The 12 months of employment do not have to be consecutive. That means any time previously worked for the same employer (including seasonal work) could, in most cases, be used to meet the 12-month requirement. If the employee has a break in service that lasted seven years or more, the time worked prior to the break will not count *unless* the break is due to service covered by the Uniformed Services Employment and Reemployment Rights Act (USERRA), or there is a written agreement, including a collective bargaining agreement, outlining the employer's intention to rehire the employee after the break in service. See "FMLA Special Rules for Returning Reservists".

LEAVE ENTITLEMENT

Eligible employees may take up to **12 workweeks** of leave in a 12-month period for one or more of the following reasons:

- The birth of a son or daughter or placement of a son or daughter with the employee for adoption or foster care;
- To care for a spouse, son, daughter, or parent who has a serious health condition;
- For a serious health condition that makes the employee unable to perform the essential functions of his or her job; or
- For any qualifying exigency arising out of the fact that a spouse, son, daughter, or parent is a military member on covered active duty or call to covered active duty status.

An eligible employee may also take up to **26 workweeks** of leave during a "single 12-month period" to care for a covered servicemember with a serious injury or illness, when the employee is the spouse, son, daughter, parent, or next of kin of the servicemember. The "single 12-month period" for military caregiver leave is different from the 12-month period used for other FMLA leave reasons. *See Fact Sheets 28F: Qualifying Reasons under the FMLA and 28M: The Military Family Leave Provisions under the FMLA.*

Under some circumstances, employees may take FMLA leave on an intermittent or reduced schedule basis. That means an employee may take leave in separate blocks of time or by reducing the time he or she works each day or week for a single qualifying reason. When leave is needed for planned medical treatment, the employee must make a reasonable effort to schedule treatment so as not to unduly disrupt the employer's operations. If FMLA leave is for the birth, adoption, or foster placement of a child, use of intermittent or reduced schedule leave requires the employer's approval.

Under certain conditions, employees may choose, or employers may require employees, to "substitute" (run concurrently) accrued paid leave, such as sick or vacation leave, to cover some or all of the FMLA leave period. An employee's ability to substitute accrued paid leave is determined by the terms and conditions of the employer's normal leave policy.

NOTICE

Employees must comply with their employer's usual and customary requirements for requesting leave and provide enough information for their employer to reasonably determine whether the FMLA may apply to the leave request. Employees generally must request leave 30 days in advance when the need for leave is foreseeable. When the need for leave is foreseeable less than 30 days in advance or is unforeseeable, employees must provide notice as soon as possible and practicable under the circumstances.

When an employee seeks leave for a FMLA-qualifying reason for the first time, the employee need not expressly assert FMLA rights or even mention the FMLA. If an employee later requests additional leave for the same qualifying condition, the employee must specifically reference either the qualifying reason for leave or the need for FMLA leave. *See Fact Sheet 28E: Employee Notice Requirements under the FMLA .*

Covered employers must:

- (1) Post a notice explaining rights and responsibilities under the FMLA. Covered employers may be subject to a civil money penalty for willful failure to post. For current penalty amounts, see www.dol.gov/whd/fmla/applicable_laws.htm;
- (2) Include information about the FMLA in their employee handbooks or provide information to new employees upon hire;

- (3) When an employee requests FMLA leave or the employer acquires knowledge that leave may be for a FMLA-qualifying reason, provide the employee with notice concerning his or her eligibility for FMLA leave and his or her rights and responsibilities under the FMLA; and
- (4) Notify employees whether leave is designated as FMLA leave and the amount of leave that will be deducted from the employee's FMLA entitlement.

See Fact Sheet 28D: Employer Notice Requirements under the FMLA.

CERTIFICATION

When an employee requests FMLA leave due to his or her own serious health condition or a covered family member's serious health condition, the employer may require certification in support of the leave from a health care provider. An employer may also require second or third medical opinions (at the employer's expense) and periodic recertification of a serious health condition. See Fact Sheet 28G: Certification of a Serious Health Condition under the FMLA. For information on certification requirements for military family leave, See Fact Sheet 28M(c): Qualifying Exigency Leave under the FMLA; Fact Sheet 28M(a): Military Caregiver Leave for a Current Servicemember under the FMLA; and Fact Sheet 28M(b): Military Caregiver Leave for a Veteran under the FMLA.

JOB RESTORATION AND HEALTH BENEFITS

Upon return from FMLA leave, an employee must be restored to his or her original job or to an equivalent job with equivalent pay, benefits, and other terms and conditions of employment. An employee's use of FMLA leave cannot be counted against the employee under a "no-fault" attendance policy. Employers are also required to continue group health insurance coverage for an employee on FMLA leave under the same terms and conditions as if the employee had not taken leave. See Fact Sheet 28A: Employee Protections under the Family and Medical Leave Act .

OTHER PROVISIONS

Special rules apply to employees of local education agencies. Generally, these rules apply to intermittent or reduced schedule FMLA leave or the taking of FMLA leave near the end of a school term.

Salaried executive, administrative, and professional employees of covered employers who meet the Fair Labor Standards Act (FLSA) criteria for exemption from minimum wage and overtime under the FLSA regulations, 29 CFR Part 541, do not lose their FLSA-exempt status by using any unpaid FMLA leave. This special exception to the "salary basis" requirements for FLSA's exemption extends only to an eligible employee's use of FMLA leave.

ENFORCEMENT

It is unlawful for any employer to interfere with, restrain, or deny the exercise of or the attempt to exercise any right provided by the FMLA. It is also unlawful for an employer to discharge or discriminate against any individual for opposing any practice, or because of involvement in any

proceeding, related to the FMLA. See Fact Sheet 77B: Protections for Individuals under the FMLA . The Wage and Hour Division is responsible for administering and enforcing the FMLA for most employees. Most federal and certain congressional employees are also covered by the law but are subject to the jurisdiction of the U.S. Office of Personnel Management or Congress. If you believe that your rights under the FMLA have been violated, you may file a complaint with the Wage and Hour Division or file a private lawsuit against your employer in court.

For additional information, visit our Wage and Hour Division Website:

<http://www.wagehour.dol.gov> and/or call our toll-free information and helpline, available 8 a.m. to 5 p.m. in your time zone, 1-866-4-USWAGE (1-866-487-9243).

This publication is for general information and is not to be considered in the same light as official statements of position contained in the regulations.

U.S. Department of Labor
Frances Perkins Building
200 Constitution Avenue, NW
Washington, DC 20210

1-866-4-USWAGE
TTY: 1-866-487-9243
Contact Us

Notice of Eligibility and Rights & Responsibilities
(Family and Medical Leave Act)

U.S. Department of Labor
Wage and Hour Division



OMB Control Number: 1235-0003
Expires: 8/31/2021

In general, to be eligible an employee must have worked for an employer for at least 12 months, meet the hours of service requirement in the 12 months preceding the leave, and work at a site with at least 50 employees within 75 miles. While use of this form by employers is optional, a fully completed Form WH-381 provides employees with the information required by 29 C.F.R. § 825.300(b), which must be provided within five business days of the employee notifying the employer of the need for FMLA leave. Part B provides employees with information regarding their rights and responsibilities for taking FMLA leave, as required by 29 C.F.R. § 825.300(b), (c).

[Part A – NOTICE OF ELIGIBILITY]

TO: _____
Employee

FROM: _____
Employer Representative

DATE: _____

On _____, you informed us that you needed leave beginning on _____ for:

- _____ The birth of a child, or placement of a child with you for adoption or foster care;
- _____ Your own serious health condition;
- _____ Because you are needed to care for your _____ spouse; _____ child; _____ parent due to his/her serious health condition.
- _____ Because of a qualifying exigency arising out of the fact that your _____ spouse; _____ son or daughter; _____ parent is on covered active duty or call to covered active duty status with the Armed Forces.
- _____ Because you are the _____ spouse; _____ son or daughter; _____ parent; _____ next of kin of a covered servicemember with a serious injury or illness.

This Notice is to inform you that you:

- _____ Are eligible for FMLA leave (See Part B below for Rights and Responsibilities)
- _____ Are **not** eligible for FMLA leave, because (only one reason need be checked, although you may not be eligible for other reasons):
- _____ You have not met the FMLA's 12-month length of service requirement. As of the first date of requested leave, you will have worked approximately _____ months towards this requirement.
- _____ You have not met the FMLA's hours of service requirement.
- _____ You do not work and/or report to a site with 50 or more employees within 75-miles.

If you have any questions, contact _____ or view the
FMLA poster located in _____.

[PART B-RIGHTS AND RESPONSIBILITIES FOR TAKING FMLA LEAVE]

As explained in Part A, you meet the eligibility requirements for taking FMLA leave and still have FMLA leave available in the applicable 12-month period. **However, in order for us to determine whether your absence qualifies as FMLA leave, you must return the following information to us by _____.** (If a certification is requested, employers must allow at least 15 calendar days from receipt of this notice; additional time may be required in some circumstances.) If sufficient information is not provided in a timely manner, your leave may be denied.

- _____ Sufficient certification to support your request for FMLA leave. A certification form that sets forth the information necessary to support your request _____ is/_____ is not enclosed.
- _____ Sufficient documentation to establish the required relationship between you and your family member.
- _____ Other information needed (such as documentation for military family leave): _____

No additional information requested

CONTINUED ON NEXT PAGE

Form WH-381 Revised February 2013

If your leave does qualify as FMLA leave you will have the following responsibilities while on FMLA leave (only checked blanks apply):

_____ Contact _____ at _____ to make arrangements to continue to make your share of the premium payments on your health insurance to maintain health benefits while you are on leave. You have a minimum 30-day (or, indicate longer period, if applicable) grace period in which to make premium payments. If payment is not made timely, your group health insurance may be cancelled, provided we notify you in writing at least 15 days before the date that your health coverage will lapse, or, at our option, we may pay your share of the premiums during FMLA leave, and recover these payments from you upon your return to work.

_____ You will be required to use your available paid _____ sick, _____ vacation, and/or _____ other leave during your FMLA absence. This means that you will receive your paid leave and the leave will also be considered protected FMLA leave and counted against your FMLA leave entitlement.

_____ Due to your status within the company, you are considered a "key employee" as defined in the FMLA. As a "key employee," restoration to employment may be denied following FMLA leave on the grounds that such restoration will cause substantial and grievous economic injury to us. We _____ have/_____ have not determined that restoring you to employment at the conclusion of FMLA leave will cause substantial and grievous economic harm to us.

_____ While on leave you will be required to furnish us with periodic reports of your status and intent to return to work every _____.
(Indicate interval of periodic reports, as appropriate for the particular leave situation).

If the circumstances of your leave change, and you are able to return to work earlier than the date indicated on the this form, you will be required to notify us at least two workdays prior to the date you intend to report for work.

If your leave does qualify as FMLA leave you will have the following rights while on FMLA leave:

- You have a right under the FMLA for up to 12 weeks of unpaid leave in a 12-month period calculated as:
 - _____ the calendar year (January – December).
 - _____ a fixed leave year based on _____
 - _____ the 12-month period measured forward from the date of your first FMLA leave usage.
 - _____ a "rolling" 12-month period measured backward from the date of any FMLA leave usage.
- You have a right under the FMLA for up to 26 weeks of unpaid leave in a single 12-month period to care for a covered servicemember with a serious injury or illness. This single 12-month period commenced on _____
- Your health benefits must be maintained during any period of unpaid leave under the same conditions as if you continued to work.
- You must be reinstated to the same or an equivalent job with the same pay, benefits, and terms and conditions of employment on your return from FMLA-protected leave. (If your leave extends beyond the end of your FMLA entitlement, you do not have return rights under FMLA.)
- If you do not return to work following FMLA leave for a reason other than: 1) the continuation, recurrence, or onset of a serious health condition which would entitle you to FMLA leave; 2) the continuation, recurrence, or onset of a covered servicemember's serious injury or illness which would entitle you to FMLA leave; or 3) other circumstances beyond your control, you may be required to reimburse us for our share of health insurance premiums paid on your behalf during your FMLA leave.
- If we have not informed you above that you must use accrued paid leave while taking your unpaid FMLA leave entitlement, you have the right to have _____ sick, _____ vacation, and/or _____ other leave run concurrently with your unpaid leave entitlement, provided you meet any applicable requirements of the leave policy. Applicable conditions related to the substitution of paid leave are referenced or set forth below. If you do not meet the requirements for taking paid leave, you remain entitled to take unpaid FMLA leave.

_____ For a copy of conditions applicable to sick/vacation/other leave usage please refer to _____ available at: _____

_____ Applicable conditions for use of paid leave: _____

Once we obtain the information from you as specified above, we will inform you, within 5 business days, whether your leave will be designated as FMLA leave and count towards your FMLA leave entitlement. If you have any questions, please do not hesitate to contact:

_____ at _____

PAPERWORK REDUCTION ACT NOTICE AND PUBLIC BURDEN STATEMENT

It is mandatory for employers to provide employees with notice of their eligibility for FMLA protection and their rights and responsibilities. 29 U.S.C. § 2617; 29 C.F.R. § 825.300(b), (c). 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 10 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 WAGE AND HOUR DIVISION.**

Designation Notice
(Family and Medical Leave Act)

U.S. Department of Labor
Wage and Hour Division



OMB Control Number: 1235-0003

Expires: 8/31/2021

Leave covered under the Family and Medical Leave Act (FMLA) must be designated as FMLA-protected and the employer must inform the employee of the amount of leave that will be counted against the employee's FMLA leave entitlement. In order to determine whether leave is covered under the FMLA, the employer may request that the leave be supported by a certification. If the certification is incomplete or insufficient, the employer must state in writing what additional information is necessary to make the certification complete and sufficient. While use of this form by employers is optional, a fully completed Form WH-382 provides an easy method of providing employees with the written information required by 29 C.F.R. §§ 825.300(c), 825.301, and 825.305(c).

To: _____

Date: _____

We have reviewed your request for leave under the FMLA and any supporting documentation that you have provided.
We received your most recent information on _____ and decided:

_____ Your FMLA leave request is approved. All leave taken for this reason will be designated as FMLA leave.

The FMLA requires that you notify us as soon as practicable if dates of scheduled leave change or are extended, or were initially unknown. Based on the information you have provided to date, we are providing the following information about the amount of time that will be counted against your leave entitlement:

_____ Provided there is no deviation from your anticipated leave schedule, the following number of hours, days, or weeks will be counted against your leave entitlement: _____

_____ Because the leave you will need will be unscheduled, it is not possible to provide the hours, days, or weeks that will be counted against your FMLA entitlement at this time. You have the right to request this information once in a 30-day period (if leave was taken in the 30-day period).

Please be advised (check if applicable):

_____ You have requested to use paid leave during your FMLA leave. Any paid leave taken for this reason will count against your FMLA leave entitlement.

_____ We are requiring you to substitute or use paid leave during your FMLA leave.

_____ You will be required to present a fitness-for-duty certificate to be restored to employment. If such certification is not timely received, your return to work may be delayed until certification is provided. A list of the essential functions of your position _____ is _____ is not attached. If attached, the fitness-for-duty certification must address your ability to perform these functions.

_____ **Additional information is needed to determine if your FMLA leave request can be approved:**

_____ The certification you have provided is not complete and sufficient to determine whether the FMLA applies to your leave request. You must provide the following information no later than _____, unless it is not practicable under the particular circumstances despite your diligent good faith efforts, or your leave may be denied.

(Specify information needed to make the certification complete and sufficient)

_____ We are exercising our right to have you obtain a second or third opinion medical certification at our expense, and we will provide further details at a later time.

_____ Your FMLA Leave request is Not Approved.

_____ The FMLA does not apply to your leave request.

_____ You have exhausted your FMLA leave entitlement in the applicable 12-month period.

PAPERWORK REDUCTION ACT NOTICE AND PUBLIC BURDEN STATEMENT

It is mandatory for employers to inform employees in writing whether leave requested under the FMLA has been determined to be covered under the FMLA. 29 U.S.C. § 2617; 29 C.F.R. §§ 825.300(d), (e). 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 10 – 30 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 WAGE AND HOUR DIVISION.**

Fact Sheet #28M: The Military Family Leave Provisions under the Family and Medical Leave Act

The military family leave provisions of the Family and Medical Leave Act (FMLA) entitle eligible employees of covered employers to take FMLA leave for any “qualifying exigency” arising from the foreign deployment of the employee’s spouse, son, daughter, or parent with the Armed Forces, or to care for a servicemember with a serious injury or illness if the employee is the servicemember’s spouse, son, daughter, parent or next of kin.

QUALIFYING EXIGENCY LEAVE

A covered employer must grant an eligible employee up to **12 workweeks** of unpaid, job-protected leave during any 12-month period for qualifying exigencies that arise when the employee’s spouse, son, daughter, or parent is on covered active duty or has been notified of an impending call or order to covered active duty.

Covered active duty means:

- for members of the **Regular** Armed Forces, duty during deployment of the member with the Armed Forces to a foreign country; or
- for members of the **Reserve** components of the Armed Forces (members of the National Guard and Reserves), duty during deployment of the member with the Armed Forces to a foreign country under a call or order to active duty in support of a contingency operation.

Deployment to a foreign country includes deployment to international waters.

Qualifying exigencies for which an employee may take FMLA leave include making alternative child care arrangements for a child of the deployed military member, attending certain military ceremonies and briefings, or making financial or legal arrangements to address the military member’s absence. See Fact Sheet 28M(c), Qualifying Exigency Leave, for additional information about qualifying exigencies under the FMLA.

MILITARY CAREGIVER LEAVE

A covered employer must grant an eligible employee up to a total of **26 workweeks** of unpaid, job-protected leave during a “single 12-month period” to care for a covered servicemember with a serious injury or illness. The employee must be the spouse, son, daughter, parent, or next of kin of the covered servicemember.

A covered servicemember is either:

- a **current** member of the Armed Forces (including a member of the National Guard or Reserves) who is undergoing medical treatment, recuperation, or therapy, is in outpatient status, or is on the temporary disability retired list, for a serious injury or illness, or

- a **veteran** of the Armed Forces (including the National Guard or Reserves) discharged within the five-year period before the family member first takes military caregiver leave to care for the veteran and who is undergoing medical treatment, recuperation, or therapy for a qualifying serious injury or illness. A veteran who was dishonorably discharged does not meet the FMLA definition of a covered servicemember.

For a current servicemember, a serious injury or illness is one that may render the servicemember medically unfit to perform his or her military duties. For a veteran, a serious injury or illness is one that rendered the veteran medically unfit to perform his or her military duties, or an injury or illness that qualifies the veteran for certain benefits from the Department of Veterans Affairs or substantially impairs the veteran's ability to work. For veterans, it includes injuries or illnesses that were incurred or aggravated during military service but that did not manifest until after the veteran left active duty.

See Fact Sheets 28M(a), Military Caregiver Leave for a Current Servicemember under the FMLA and 28M(b), Military Caregiver Leave for Veteran under the FMLA, for additional information on these provisions, including the definition of a serious injury or illness for a covered servicemember, and certification requirements. See also the "Employee's Guide to the Family and Medical Leave Act" and the "Employee's Guide to Military Family Leave" for additional information, including the employee's requirement to provide notice of their need for leave.

ENFORCEMENT

It is unlawful for any employer to interfere with, restrain, or deny the exercise of or the attempt to exercise any right provided by the FMLA. It is also unlawful for an employer to discharge or discriminate against any individual for opposing any practice, or because of involvement in any proceeding, related to the FMLA. See Fact Sheet 77B: Protections for Individuals under the FMLA. The Wage and Hour Division is responsible for administering and enforcing the FMLA for most employees. Most federal and certain congressional employees are also covered by the law but are subject to the jurisdiction of the U.S. Office of Personnel Management or Congress. If you believe that your rights under the FMLA have been violated, you may file a complaint with the Wage and Hour Division or file a private lawsuit against your employer in court.

For additional information, visit our Wage and Hour Division Website: <http://www.wagehour.dol.gov> and/or call our toll-free information and helpline, available 8 a.m. to 5 p.m. in your time zone, 1-866-4USWAGE (1-866-487-9243).

This publication is for general information and is not to be considered in the same light as official statements of position contained in the regulations.

For Information on the effective date, click here.

U.S. Department of Labor
Frances Perkins Building
200 Constitution Avenue, NW
Washington, DC 20210

1-866-4-USWAGE
TTY: 1-866-487-9243
Contact Us

Fact Sheet #28M(a): Military Caregiver Leave for a Current Servicemember under the Family and Medical Leave Act

The Family and Medical Leave Act (FMLA) entitles eligible employees who work for covered employers to take unpaid, job-protected leave to care for a family member who is a current servicemember with a serious injury or illness. FMLA leave for this purpose is called “military caregiver leave.”

MILITARY CAREGIVER LEAVE ENTITLEMENTS

Military caregiver leave allows an eligible employee who is the spouse, son, daughter, parent, or next of kin of a covered servicemember with a serious injury or illness to take up to a total of **26 workweeks** of unpaid leave during a “single 12-month period” to provide care for the servicemember.

A **covered servicemember** is a current member of the Armed Forces, including a member of the National Guard or Reserves, who is receiving medical treatment, recuperation, or therapy, **or** is in outpatient status, **or** is on the temporary disability retired list for a serious injury or illness. A **serious injury or illness** is one that is incurred by a servicemember in the line of duty on active duty that may cause the servicemember to be medically unfit to perform the duties of his or her office, grade, rank, or rating. A serious injury or illness also includes injuries or illnesses that existed before the servicemember’s active duty and that were aggravated by service in the line of duty on active duty.

NEXT OF KIN

The “next of kin” of a current servicemember is the nearest blood relative, other than the current servicemember’s spouse, parent, son, or daughter, in the following order of priority:

1. a blood relative who has been designated *in writing* by the servicemember as the next of kin for FMLA purposes
2. blood relative who has been granted legal custody of the servicemember
3. brothers and sisters
4. grandparents
5. aunts and uncles
6. first cousins

When a servicemember designates in writing a blood relative as next of kin for FMLA purposes, that individual is deemed to be the servicemember’s only FMLA next of kin. When a current servicemember has not designated in writing a next of kin for FMLA purposes, and there are

multiple family members with the same level of relationship to the servicemember, all such family members are considered the servicemember's next of kin and may take FMLA leave to provide care to the servicemember.

For example, if a current servicemember has three siblings and has not designated a blood relative to provide care, all three siblings would be considered the servicemember's next of kin. Alternatively, where a current servicemember has one or more siblings and designates a cousin as his or her next of kin for FMLA purposes, then only the designated cousin is eligible as the servicemember's next of kin.

SINGLE 12-MONTH PERIOD

The single 12-month period for military caregiver leave begins on the first day the employee takes leave for this reason and ends 12 months later, regardless of the 12-month period established by the employer for other FMLA leave reasons.

An eligible employee is limited to a *combined* total of 26 workweeks of leave for **any** FMLA-qualifying reasons during the single 12-month period. Up to 12 of the 26 weeks may be for an FMLA-qualifying reason other than military caregiver leave. For example, if an employee uses 10 weeks of FMLA leave for his or her own serious health condition during the single 12-month period, the employee has up to 16 weeks of FMLA leave left for military caregiver leave.

Military caregiver leave is available to an eligible employee once per servicemember, per serious injury or illness. However, an eligible employee may take an additional 26 weeks of leave in a different 12-month period to care for the same servicemember if he or she has another serious injury or illness. For example, if an eligible employee takes military caregiver leave to care for a current servicemember who sustained severe burns, the employee would be entitled to an additional 26 weeks of caregiver leave in a different 12-month period if the same servicemember is later diagnosed with a traumatic brain injury that was incurred in the same incident as the burns.

An eligible employee may also take military caregiver leave to care for more than one current servicemember or covered veteran with a serious injury or illness at the same time, but the employee is limited to a total of 26 weeks of military caregiver leave in any single 12-month period. Additionally, an eligible employee may be able to take military caregiver leave for the same family member with the same serious injury or illness both when the family member is a current servicemember and when the family member is a veteran.

CERTIFICATION REQUIREMENTS

An employer may require that leave to care for a covered servicemember be supported by a certification completed by an authorized health care provider **or** by a copy of an Invitational Travel Order (ITO) or Invitational Travel Authorization (ITA) issued to any member of the

covered servicemember's family. Employees may use the U. S. Department of Labor's optional form WH-385.

An authorized health care provider is a:

- (1) United States Department of Defense ("DOD") health care provider;
- (2) United States Department of Veterans Affairs ("VA") health care provider;
- (3) DOD TRICARE network authorized private health care provider;
- (4) DOD non-network TRICARE authorized private health care provider; or
- (5) non-military-affiliated health care provider.

An employer may request a second or third opinion of a current servicemember's serious injury or illness only when a certification is provided by a non-military-affiliated health care provider.

ENFORCEMENT

It is unlawful for any employer to interfere with, restrain, or deny the exercise of or the attempt to exercise any right provided by the FMLA. It is also unlawful for an employer to discharge or discriminate against any individual for opposing any practice, or because of involvement in any proceeding, related to the FMLA. See Fact Sheet 77B: Protections for Individuals under the FMLA. The Wage and Hour Division is responsible for administering and enforcing the FMLA for most employees. Most federal and certain congressional employees are also covered by the law but are subject to the jurisdiction of the U.S. Office of Personnel Management or Congress. If you believe that your rights under the FMLA have been violated, you may file a complaint with the Wage and Hour Division or file a private lawsuit against your employer in court.

For additional information, visit our Wage and Hour Division Website:

<http://www.wagehour.dol.gov> and/or call our toll-free information and helpline, available 8 a.m. to 5 p.m. in your time zone, 1-866-4USWAGE (1-866-487-9243).

This publication is for general information and is not to be considered in the same light as official statements of position contained in the regulations.

For information on the effective date, [click here](#).

U.S. Department of Labor
Frances Perkins Building
200 Constitution Avenue, NW
Washington, DC 20210

1-866-4-USWAGE
TTY: 1-866-487-9243
Contact Us

Fact Sheet #28M(b): Military Caregiver Leave for a Veteran under the Family and Medical Leave Act

The Family and Medical Leave Act (FMLA) entitles eligible employees who work for covered employers to take unpaid, job-protected leave to care for a family member who is a covered veteran with a “serious injury or illness”. FMLA leave for this purpose is called “military caregiver leave.”

MILITARY CAREGIVER LEAVE ENTITLEMENTS

Military caregiver leave allows an eligible employee who is the spouse, son, daughter, parent, or “next of kin” of a covered veteran with a serious injury or illness to take up to a total of **26 workweeks** of unpaid leave during a “single 12-month period” to provide care for the veteran.

A veteran who is undergoing medical treatment, recuperation, or therapy for a serious injury or illness is a **covered veteran** if he or she:

- was a member of the Armed Forces (including a member of the National Guard or Reserves);
- was discharged or released under conditions other than dishonorable; and
- was discharged within the five-year period before the eligible employee first takes FMLA military caregiver leave to care for him or her.*

* For a veteran who was discharged prior to March 8, 2013, the effective date of the FMLA Final Rule, the period between October 28, 2009 and March 8, 2013 will not count towards the determination of the five-year period. For example, if a servicemember retired on October 28, 2007, he or she would have had three years remaining of the five-year period on October 28, 2009. The family member requesting FMLA leave will have three years to begin military caregiver leave starting on March 8, 2013. Likewise, if a servicemember was discharged on December 1, 2010, the five-year period will begin on March 8, 2013 and extend until March 8, 2018.

SERIOUS INJURY OR ILLNESS

A serious injury or illness means an injury or illness that was incurred by the covered veteran in the line of duty on active duty in the Armed Forces or that existed before the veteran’s active duty and was aggravated by service in the line of duty on active duty, and that is either:

1. a continuation of a serious injury or illness that was incurred or aggravated when the 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*
2. a physical or mental condition for which the veteran has received a U.S. Department of Veterans Affairs Service-Related Disability Rating (VASRD) of 50 percent or greater, and the need for military caregiver leave is related to that condition; *or*
3. a physical or mental condition that substantially impairs the veteran's ability to work because of a disability or disabilities related to military service, or would do so absent treatment; *or*
4. an injury that is the basis for the veteran's enrollment in the Department of Veterans Affairs Program of Comprehensive Assistance for Family Caregivers.

Any *one* of these definitions meets the FMLA's definition of a serious injury or illness for a covered veteran regardless of whether the injury or illness manifested before or after the individual became a veteran.

NEXT OF KIN

The "next of kin" of a covered veteran is the nearest blood relative, other than the veteran's spouse, parent, son, or daughter, in the following order of priority:

1. a blood relative who has been designated *in writing* by the servicemember as the next of kin for FMLA purposes
2. blood relative who has been granted legal custody of the servicemember
3. brothers and sisters
4. grandparents
5. aunts and uncles
6. first cousins

When the veteran designates in writing a blood relative as next of kin for FMLA purposes, that individual is deemed to be the veteran's only FMLA next of kin. When the veteran has not designated in writing a next of kin for FMLA purposes, and there are multiple family members with the same level of relationship to the veteran, all such family members are considered the veteran's next of kin and may take FMLA leave to provide care to the veteran.

For example, if the veteran has three siblings and has not designated a blood relative to provide care, all three siblings would be considered the veteran's next of kin. Alternatively, where the veteran has one or more siblings and designates a cousin as his or her next of kin for FMLA purposes, then only the designated cousin is eligible as the veteran's next of kin.

SINGLE 12-MONTH PERIOD

The single 12-month period for military caregiver leave begins on the first day the employee takes leave for this reason and ends 12 months later, regardless of the 12-month period established by the employer for other FMLA leave reasons.

An eligible employee is limited to a *combined* total of 26 workweeks of leave for **any** FMLA-qualifying reasons during the single 12-month period. Up to 12 of the 26 weeks may be for an FMLA-qualifying reason other than military caregiver leave. For example, if an employee uses 10 weeks of FMLA leave for his or her own serious health condition during the single 12-month period, the employee has up to 16 weeks of FMLA leave left for military caregiver leave.

Military caregiver leave is available to an eligible employee once per veteran, per serious injury or illness. However, an eligible employee may take an additional 26 weeks of leave in a different 12-month period to care for the same veteran if he or she has another serious injury or illness. For example, if an eligible employee takes caregiver leave to care for a veteran who sustained severe burns that rendered him unable to perform his military duties when he was a current servicemember and for which he continues to need care as a veteran, the employee would be entitled to an additional 26 weeks of caregiver leave in a different 12-month period if the veteran is later diagnosed with a traumatic brain injury that was incurred in the same incident as the burns.

An eligible employee may also take military caregiver leave to care for more than one covered veteran or current servicemember with a serious injury or illness at the same time, but the employee is limited to a total of 26 weeks of military caregiver leave in any single 12-month period. Additionally, an eligible employee may be able to take military caregiver leave for the same family member with the same serious injury or illness both when the family member is a current servicemember and when the family member is a veteran.

CERTIFICATION REQUIREMENTS

An employer may require that leave to care for a veteran be supported by a certification completed by an authorized health care provider. An employee may submit a copy of a VASRD rating determination or enrollment documentation from the VA Program of Comprehensive Assistance for Family Caregivers to certify that the veteran has a serious injury or illness. This documentation is sufficient regardless of whether the employee is the named caregiver. However, if the employee submits such documents, the employee may still be required to provide confirmation of family relationship and documentation of discharge date and status for a complete certification. Employees may use the U. S. Department of Labor's optional form WH-385-V.

An authorized health care provider may be a:

- (1) United States Department of Defense ("DOD") health care provider;
- (2) United States Department of Veterans Affairs ("VA") health care provider;

- (3) DOD TRICARE network authorized private health care provider;
- (4) DOD non-network TRICARE authorized private health care provider; or
- (5) non-military-affiliated health care provider.

An employer may request a second and third opinion of a covered veteran's serious injury or illness only when a certification is provided by a non-military-affiliated health care provider.

ENFORCEMENT

It is unlawful for any employer to interfere with, restrain, or deny the exercise of or the attempt to exercise any right provided by the FMLA. It is also unlawful for an employer to discharge or discriminate against any individual for opposing any practice, or because of involvement in any proceeding, related to the FMLA. See Fact Sheet 77B: Protections for Individuals under the FMLA. The Wage and Hour Division is responsible for administering and enforcing the FMLA for most employees. Most federal and certain congressional employees are also covered by the law but are subject to the jurisdiction of the U.S. Office of Personnel Management or Congress. If you believe that your rights under the FMLA have been violated, you may file a complaint with the Wage and Hour Division or file a private lawsuit against your employer in court.

For additional information, visit our Wage and Hour Division Website:

<http://www.wagehour.dol.gov> and/or call our toll-free information and helpline, available 8 a.m. to 5 p.m. in your time zone, 1-866-4USWAGE (1-866-487-9243).

This publication is for general information and is not to be considered in the same light as official statements of position contained in the regulations.

For information on the effective date, [click here](#).

U.S. Department of Labor
Frances Perkins Building
200 Constitution Avenue, NW
Washington, DC 20210

1-866-4-USWAGE
TTY: 1-866-487-9243
Contact Us

**Certification of Health Care Provider for
Employee's Serious Health Condition
(Family and Medical Leave Act)**

U.S. Department of Labor

Wage and Hour Division



DO NOT SEND COMPLETED FORM TO THE DEPARTMENT OF LABOR; RETURN TO THE PATIENT

OMB Control Number: 1235-0003
Expires: 8/31/2021

SECTION I: For Completion by the EMPLOYER

INSTRUCTIONS to the EMPLOYER: The Family and Medical Leave Act (FMLA) provides that an employer may require an employee seeking FMLA protections because of a need for leave due to a serious health condition to submit a medical certification issued by the employee's health care provider. Please complete Section I before giving this form to your employee. 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. §§ 825.306-825.308. Employers must generally maintain records and documents relating to medical certifications, recertifications, or medical histories of employees 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, and in accordance with 29 C.F.R. § 1635.9, if the Genetic Information Nondiscrimination Act applies.

Employer name and contact: _____

Employee's job title: _____ Regular work schedule: _____

Employee's essential job functions: _____

Check if job description is attached: _____

SECTION II: For Completion by the EMPLOYEE

INSTRUCTIONS to the EMPLOYEE: Please complete Section II before giving this form to your medical provider. The FMLA permits an employer to require that you submit a timely, complete, and sufficient medical certification to support a request for FMLA leave due to your own serious health condition. If requested by your employer, your response is required to obtain or retain the benefit of FMLA protections. 29 U.S.C. §§ 2613, 2614(c)(3). Failure to provide a complete and sufficient medical certification may result in a denial of your FMLA request. 29 C.F.R. § 825.313. Your employer must give you at least 15 calendar days to return this form. 29 C.F.R. § 825.305(b).

Your name: _____
First Middle Last

SECTION III: For Completion by the HEALTH CARE PROVIDER

INSTRUCTIONS to the HEALTH CARE PROVIDER: Your patient has requested leave under the FMLA. 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. Do not provide information about genetic tests, as defined in 29 C.F.R. § 1635.3(f), genetic services, as defined in 29 C.F.R. § 1635.3(e), or the manifestation of disease or disorder in the employee's family members, 29 C.F.R. § 1635.3(b). Please be sure to sign the form on the last page.

Provider's name and business address: _____

Type of practice / Medical specialty: _____

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

PART A: MEDICAL FACTS

1. Approximate date condition commenced: _____

Probable duration of condition: _____

Mark below as applicable:

Was the patient admitted for an overnight stay in a hospital, hospice, or residential medical care facility?

___ No ___ Yes. If so, dates of admission: _____

Date(s) you treated the patient for condition: _____

Will the patient need to have treatment visits at least twice per year due to the condition? ___ No ___ Yes.

Was medication, other than over-the-counter medication, prescribed? ___ No ___ Yes.

Was the patient referred to other health care provider(s) for evaluation or treatment (e.g., physical therapist)?
___ No ___ Yes. If so, state the nature of such treatments and expected duration of treatment: _____

2. Is the medical condition pregnancy? ___ No ___ Yes. If so, expected delivery date: _____

3. Use the information provided by the employer in Section I to answer this question. If the employer fails to provide a list of the employee's essential functions or a job description, answer these questions based upon the employee's own description of his/her job functions.

Is the employee unable to perform any of his/her job functions due to the condition: ___ No ___ Yes.

If so, identify the job functions the employee is unable to perform: _____

4. Describe other relevant medical facts, if any, related to the condition for which the employee seeks leave (such medical facts may include symptoms, diagnosis, or any regimen of continuing treatment such as the use of specialized equipment):

PART B: AMOUNT OF LEAVE NEEDED

5. Will the employee be incapacitated for a single continuous period of time due to his/her medical condition, including any time for treatment and recovery? ___No ___Yes.

If so, estimate the beginning and ending dates for the period of incapacity: _____

6. Will the employee need to attend follow-up treatment appointments or work part-time or on a reduced schedule because of the employee's medical condition? ___No ___Yes.

If so, are the treatments or the reduced number of hours of work medically necessary?
___No ___Yes.

Estimate treatment schedule, if any, including the dates of any scheduled appointments and the time required for each appointment, including any recovery period:

Estimate the part-time or reduced work schedule the employee needs, if any:

_____ hour(s) per day; _____ days per week from _____ through _____

7. Will the condition cause episodic flare-ups periodically preventing the employee from performing his/her job functions? ___No ___Yes.

Is it medically necessary for the employee to be absent from work during the flare-ups?
___ No ___ Yes. If so, explain:

Based upon the patient's medical history and your knowledge of the medical condition, estimate the frequency of flare-ups and the duration of related incapacity that the patient may have over the next 6 months (e.g., 1 episode every 3 months lasting 1-2 days):

Frequency : _____ times per _____ week(s) _____ month(s)

Duration: _____ hours or _____ day(s) per episode

ADDITIONAL INFORMATION: IDENTIFY QUESTION NUMBER WITH YOUR ADDITIONAL ANSWER.

Certification of Health Care Provider for
Family Member's Serious Health Condition
(Family and Medical Leave Act)

U.S. Department of Labor
Wage and Hour Division



DO NOT SEND COMPLETED FORM TO THE DEPARTMENT OF LABOR; RETURN TO THE PATIENT.

OMB Control Number: 1235-0003

Expires: 8/31/2021

SECTION I: For Completion by the EMPLOYER

INSTRUCTIONS to the EMPLOYER: The Family and Medical Leave Act (FMLA) provides that an employer may require an employee seeking FMLA protections because of a need for leave to care for a covered family member with a serious health condition to submit a medical certification issued by the health care provider of the covered family member. Please complete Section I before giving this form to your employee. 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. §§ 825.306-825.308. Employers must generally maintain records and documents relating to medical certifications, recertifications, or medical histories of 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, and in accordance with 29 C.F.R. § 1635.9, if the Genetic Information Nondiscrimination Act applies.

Employer name and contact: _____

SECTION II: For Completion by the EMPLOYEE

INSTRUCTIONS to the EMPLOYEE: Please complete Section II before giving this form to your family member or his/her medical provider. The FMLA permits an employer to require that you submit a timely, complete, and sufficient medical certification to support a request for FMLA leave to care for a covered family member with a serious health condition. If requested by your employer, your response is required to obtain or retain the benefit of FMLA protections. 29 U.S.C. §§ 2613, 2614(c)(3). Failure to provide a complete and sufficient medical certification may result in a denial of your FMLA request. 29 C.F.R. § 825.313. Your employer must give you at least 15 calendar days to return this form to your employer. 29 C.F.R. § 825.305.

Your name: _____
First Middle Last

Name of family member for whom you will provide care: _____
First Middle Last

Relationship of family member to you: _____

If family member is your son or daughter, date of birth: _____

Describe care you will provide to your family member and estimate leave needed to provide care:

Employee Signature _____ Date _____

SECTION III: For Completion by the HEALTH CARE PROVIDER

INSTRUCTIONS to the HEALTH CARE PROVIDER: The employee listed above has requested leave under the FMLA to care for your patient. Answer, fully and completely, all applicable parts below. 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 patient needs leave. 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). Page 3 provides space for additional information, should you need it. Please be sure to sign the form on the last page.

Provider's name and business address: _____

Type of practice / Medical specialty: _____

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

PART A: MEDICAL FACTS

1. Approximate date condition commenced: _____

Probable duration of condition: _____

Was the patient admitted for an overnight stay in a hospital, hospice, or residential medical care facility?

☐ No ☐ Yes. If so, dates of admission: _____

Date(s) you treated the patient for condition: _____

Was medication, other than over-the-counter medication, prescribed? ☐ No ☐ Yes.

Will the patient need to have treatment visits at least twice per year due to the condition? ☐ No ☐ Yes

Was the patient referred to other health care provider(s) for evaluation or treatment (e.g., physical therapist)?

☐ No ☐ Yes. If so, state the nature of such treatments and expected duration of treatment:

2. Is the medical condition pregnancy? ☐ No ☐ Yes. If so, expected delivery date: _____

3. Describe other relevant medical facts, if any, related to the condition for which the patient needs care (such medical facts may include symptoms, diagnosis, or any regimen of continuing treatment such as the use of specialized equipment):

PART B: AMOUNT OF CARE NEEDED: When answering these questions, keep in mind that your patient's need for care by the employee seeking leave may include assistance with basic medical, hygienic, nutritional, safety or transportation needs, or the provision of physical or psychological care:

4. Will the patient be incapacitated for a single continuous period of time, including any time for treatment and recovery? ☐ No ☐ Yes.

Estimate the beginning and ending dates for the period of incapacity: _____

During this time, will the patient need care? ☐ No ☐ Yes.

Explain the care needed by the patient and why such care is medically necessary:

5. Will the patient require follow-up treatments, including any time for recovery? ☐ No ☐ Yes.

Estimate treatment schedule, if any, including the dates of any scheduled appointments and the time required for each appointment, including any recovery period:

Explain the care needed by the patient, and why such care is medically necessary: _____

6. Will the patient require care on an intermittent or reduced schedule basis, including any time for recovery? ☐ No ☐ Yes.

Estimate the hours the patient needs care on an intermittent basis, if any:

_____ hour(s) per day; _____ days per week from _____ through _____

Explain the care needed by the patient, and why such care is medically necessary:

7. Will the condition cause episodic flare-ups periodically preventing the patient from participating in normal daily activities? ____ No ____ Yes.

Based upon the patient's medical history and your knowledge of the medical condition, estimate the frequency of flare-ups and the duration of related incapacity that the patient may have over the next 6 months (e.g., 1 episode every 3 months lasting 1-2 days):

Frequency: ____ times per ____ week(s) ____ month(s)

Duration: ____ hours or ____ day(s) per episode

Does the patient need care during these flare-ups? ____ No ____ Yes.

Explain the care needed by the patient, and why such care is medically necessary: _____

ADDITIONAL INFORMATION: IDENTIFY QUESTION NUMBER WITH YOUR ADDITIONAL ANSWER.

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 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.

**Certification for Serious Injury or
Illness of a Current
Servicemember - for Military Family Leave
(Family and Medical Leave Act)**

U.S. Department of Labor

Wage and Hour Division



DO NOT SEND COMPLETED FORM TO THE DEPARTMENT OF LABOR; RETURN TO THE PATIENT

OMB Control Number: 1235-0003
Expires: 8/31/2021

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 current servicemember 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 CFR 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 CFR 1630.14(c)(1), if the Americans with Disabilities Act applies, and in accordance with 29 CFR 1635.9, if the Genetic Information Nondiscrimination Act applies.

SECTION I: For Completion by the EMPLOYEE and/or the CURRENT SERVICEMEMBER for whom the Employee Is Requesting Leave

INSTRUCTIONS to the EMPLOYEE or CURRENT 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 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, 2614(c)(3). Failure to do so may result in a denial of an employee's FMLA request. 29 CFR 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; (3) a DOD non-network TRICARE authorized private health care provider; or (4) a health care provider as defined in 29 CFR 825.125

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 current 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 in the Armed Forces or that existed before the beginning of the member's active duty and was aggravated by service in the line of duty on active duty in the Armed Forces 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 leave due to a current servicemember's serious injury or illness includes written documentation confirming that the servicemember's injury or illness was incurred in the line of duty on active duty or if not, that the current servicemember's injury or illness 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 that the current 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 servicemember'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).

SECTION I: For Completion by the EMPLOYEE and/or the CURRENT SERVICEMEMBER 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 the current servicemember):

Name of Employee Requesting Leave to Care for the Current Servicemember:

First

Middle

Last

Name of the Current Servicemember (for whom employee is requesting leave to care):

First

Middle

Last

Relationship of Employee to the Current Servicemember:

Spouse ☐ Parent ☐ Son ☐ Daughter ☐ Next of Kin ☐

Part B: SERVICEMEMBER INFORMATION

- (1) Is the Servicemember a Current Member of the Regular Armed Forces, the National Guard or Reserves?
Yes ☐ No ☐

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

Is the 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, please provide the name of the medical treatment facility or unit:

- (2) Is the Servicemember on the Temporary Disability Retired List (TDRL)?
Yes ☐ No ☐

Part C: CARE TO BE PROVIDED TO THE SERVICEMEMBER

Describe the Care to Be Provided to the Current Servicemember and an Estimate of the Leave Needed to Provide the Care:

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; (3) a DOD non-network TRICARE authorized private health care provider; or (4) a health care provider as defined in 29 CFR 825.125. If you are unable to make certain of the military-related determinations contained below in Part B, you are permitted to rely upon determinations 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 state whether you are either: (1) a DOD health care provider; (2) a 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 as defined in 29 CFR 825.125:

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

PART B: MEDICAL STATUS

(1) The current Servicemember's medical condition is classified as (Check One of the Appropriate Boxes):

☐ **(VSI) 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.)

☐ **(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 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" under § 825.113 of the FMLA. If such leave is requested, you may be required to complete DOL FORM WH-380-F or an employer-provided form seeking the same information.)

(2) Is the current Servicemember being treated for a condition which was incurred or aggravated by service in the line of duty on active duty in the Armed Forces? Yes ☐ No ☐

(3) Approximate date condition commenced: _____

(4) Probable duration of condition and/or need for care: _____

- (5) Is the servicemember undergoing medical treatment, recuperation, or therapy for this condition? Yes ☐ No ☐

If yes, please describe medical treatment, recuperation or therapy:

PART C: SERVICEMEMBER'S NEED FOR CARE BY FAMILY MEMBER

- (1) Will the 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: _____

- (2) Will the servicemember require periodic follow-up treatment appointments? Yes ☐ No ☐

If yes, estimate the treatment schedule: _____

- (3) Is there a medical necessity for the servicemember to have periodic care for these follow-up treatment appointments? Yes ☐ No ☐

- (4) Is there a medical necessity for the 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, 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 AV, NW, Washington, DC 20210. **DO NOT SEND THE COMPLETED FORM TO THE WAGE AND HOUR DIVISION; RETURN IT TO THE PATIENT.**

**Certification of Qualifying Exigency
For Military Family Leave
(Family and Medical Leave Act)**

U.S. Department of Labor
Wage and Hour Division



OMB Control Number: 1235-0003
Expires: 8/31/2021

SECTION I: For Completion by 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 qualifying exigency to submit a certification. Please complete Section I before giving this form to your employee. Your response is voluntary, and 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 CFR 825.309.

Employer name: _____

Contact Information: _____

SECTION II: For Completion by the EMPLOYEE

INSTRUCTIONS to the EMPLOYEE: Please complete Section II fully and completely. The FMLA permits an employer to require that you submit a timely, complete, and sufficient certification to support a request for FMLA leave due to a qualifying exigency. Several questions in this section seek a response as to the frequency or duration of the qualifying exigency. Be as specific as you can; terms such as "unknown," or "indeterminate" may not be sufficient to determine FMLA coverage. Your response is required to obtain a benefit. 29 CFR 825.310. While you are not required to provide this information, failure to do so may result in a denial of your request for FMLA leave. Your employer must give you at least 15 calendar days to return this form to your employer.

Your Name: _____
First Middle Last

Name of military member on covered active duty or call to covered active duty status:

First Middle Last

Relationship of military member to you: _____

Period of military member's covered active duty: _____

A complete and sufficient certification to support a request for FMLA leave due to a qualifying exigency includes written documentation confirming a military member's covered active duty or call to covered active duty status. Please check one of the following and attach the indicated document to support that the military member is on covered active duty or call to covered active duty status.

A copy of the military member's covered active duty orders is attached.

Other documentation from the military certifying that the military member is on covered active duty (or has been notified of an impending call to covered active duty) is attached.

I have previously provided my employer with sufficient written documentation confirming the military member's covered active duty or call to covered active duty status.

PART A: QUALIFYING REASON FOR LEAVE

1. Describe the reason you are requesting FMLA leave due to a qualifying exigency (including the specific reason you are requesting leave):

2. A complete and sufficient certification to support a request for FMLA leave due to a qualifying exigency includes any available written documentation which supports the need for leave; such documentation may include a copy of a meeting announcement for informational briefings sponsored by the military; a document confirming the military member's Rest and Recuperation leave; a document confirming an appointment with a third party, such as a counselor or school official, or staff at a care facility; or a copy of a bill for services for the handling of legal or financial affairs. Available written documentation supporting this request for leave is attached.

Yes ☐ No ☐ None Available ☐

PART B: AMOUNT OF LEAVE NEEDED

1. Approximate date exigency commenced: _____

Probable duration of exigency: _____

2. Will you need to be absent from work for a single continuous period of time due to the qualifying exigency?

Yes ☐ No ☐

If so, estimate the beginning and ending dates for the period of absence:

3. Will you need to be absent from work periodically to address this qualifying exigency? Yes ☐ No ☐

Estimate schedule of leave, including the dates of any scheduled meetings or appointments:

Estimate the frequency and duration of each appointment, meeting, or leave event, including any travel time (i.e., 1 deployment-related meeting every month lasting 4 hours):

Frequency: _____ times per _____ week(s) _____ month(s)

Duration: _____ hours _____ day(s) per event.

PART C:

If leave is requested to meet with a third party (such as to arrange for childcare or parental care, to attend counseling, to attend meetings with school, childcare or parental care providers, to make financial or legal arrangements, to act as the military member's representative before a federal, state, or local agency for purposes of obtaining, arranging or appealing military service benefits, or to attend any event sponsored by the military or military service organizations), a complete and sufficient certification includes the name, address, and appropriate contact information of the individual or entity with whom you are meeting (i.e., either the telephone or fax number or email address of the individual or entity). This information may be used by your employer to verify that the information contained on this form is accurate.

Name of Individual: _____ Title: _____

Organization: _____

Address: _____

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

Email: _____

Describe nature of meeting: _____

PART D:

I certify that the information I provided above is true and correct.

Signature of Employee _____ Date _____

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