FIT **Fashion Institute of Technology**
State University of New York

MUST BE RETURNED TO THE OFICE OF HUMAN RESOURCES NO LATER THAN
_____ _____

CERTIFICATION FOR SERIOUS INJURY OR ILLNESS OF COVERED SERVICEMEMBER FOR MILITARY FAMILY LEAVE (FMLA)

EMPLOYEE/SERVICEMEMBER INFORMATION (to be completed by Employee or Servicemember)

Name of Employee Requesting Leave to Care for Covered Servicemember:

_____

Name of Covered Servicemember for whom employee is requesting leave to care:

_____

Relationship of Employee to Covered Servicemember: ☐ Spouse ☐ Parent ☐ Son ☐ Daughter ☐ Next of Kin

Is the Covered Servicemember a Current Member of the Regular Armed Forces, the National Guard or Reserves?
☐ No ☐ Yes If yes, provide 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 control of members of the Armed Forces receiving medical care as outpatients (such as a medical hold or warrior transition unit)? ☐ No ☐ Yes If yes, please provide the name of the medical treatment facility or unit: _____

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

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

_____

_____

_____

_____

TO BE COMPLETED BY SERVICEMEMBER TO PERMIT CONTACT WITH HEALTH CARE PROVIDER:

I **[☐ do / ☐ do not]** give the College permission to contact my health care provider(s) in order to clarify any medical certification submitted to justify my family member's leave. ***Note: Your failure to give permission will be one of the factors the College considers in determining whether to request a second medical opinion.***

_____ _____

Servicemember Signature Date

HEALTHCARE PROVIDER INFORMATION

(1) Covered 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 or an employer-provided form seeking the same information.)

(2) Was the condition for which the Covered Servicemember is being treated incurred 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 covered servicemember undergoing medical treatment, recuperation, or therapy? ____ Yes ____ No
If yes, please describe medical treatment, recuperation or therapy:

_____

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 and 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 treatment 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**

Health Care Provider's Name and Business Address:_____

_____

Type of Practice/Medical Specialty: _____

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

Please indicate whether you are either: ____ a DOD health care provider; ____ a VA health care provider; ___ a DOD TRICARE network authorized private health care provider; or ___ a DOD non-network TRICARE authorized private health care provider.

PLEASE RETURN FULLY COMPLETED FORM TO:

Office of Human Resources Fashion Institute of Technology

333 7th Avenue, 16th Floor
New York, NY 10001-5992

or Confidential Fax: (212) 217-3651