



CERTIFICATION for SERIOUS INJURY or ILLNESS of COVERED SERVICE MEMBER

(Family and Medical Leave Act of 1993; Rev. 01/09)
Wichita State University *Office of Human Resources* Wichita, Kansas 67260-0015
Phone- (316) 978-3065* Fax- (316) 978-3201

(Rev. 1/2009)

- 1. Employee's Full Name: myWSU ID#
2. Name of Covered Service Member:
3. Relationship of Employee to Covered Service Member Requesting Leave to Care:
Spouse Parent Son Daughter Next of Kin

COVERED SERVICE MEMBER INFORMATION

- 4. Is the Covered Service Member a Current Member of the Regular Armed Forces, the National Guard or Reserves?
5. Is the covered service member assigned to a military medical treatment facility as an outpatient or to a unit established for the purpose of providing command and control of members of the Armed Forces receiving medical care as outpatients (such as medical hold or warrior transition unit)?
6. Is the Covered Service Member on the Temporary Disability Retired List (TDRL)?

CARE TO BE PROVIDED TO THE COVERED SERVICE MEMBER

- 7. Describe the Care To Be Provided to the Covered Service Member and an Estimate of the Leave Needed to Provide the Care:

*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 healthcare provider; or (3) a DOD non-network TRICARE authorized private healthcare provider.

HEALTHCARE PROVIDER INFORMATION

- 8. Health Care Provider's Name: Business Address: Type of Practice/Medical Specialty:
9. 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 healthcare provider; or (4) a DOD non-network TRICARE authorized private healthcare provider:
Telephone () Fax: () Email:

MEDICAL STATUS

- 10. 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 a severity that life is imminently endangered. Family members are requested at bedside immediately.
(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.

OTHER III/Injured – a serious injury or illness that may render the service member medically unfit to perform the duties of the member’s office, grade, rank, or rating.

NONE OF THE ABOVE (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 a Wichita State University provided medical form seeking the same information.)

11. 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

12. Approximate date condition commenced: _____

13. Probable duration of condition and/or need for care: _____

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

COVERED SERVICE MEMBER’S NEED FOR CARE BY FAMILY MEMBER

15. Will the covered service member 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: _____

16. Will the covered service member require periodic follow-up treatment appointments? Yes No

If yes, estimate the treatment schedule: _____

17. Is there a medical necessity for the covered service member to have periodic care for these follow-up treatment appointments? Yes No

18. Is there a medical necessity for the covered service member 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