CERTIFICATION for SERIOUS INJURY or ILLNESS of COVERED SERVICE MEMBER
(Family and Medical Leave Act of 1993; Rev. 01/09)
Rhatigan Student Center *Human Resources Department * Wichita, Kansas 67260-0056
Phone- (316) 978-7003 * Fax- (316) 978-3217
(Rev. 6/2015)

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?
   [ ] Yes  [ ] No
   If yes, please provide the covered service member’s military branch, rank and unit currently assigned to:

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)?  [ ] Yes  [ ] No
   If yes, please provide the name of the medical treatment facility or unit:

6. Is the Covered Service Member on the Temporary Disability Retired List (TDRL)?  [ ] Yes  [ ] No

**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: ______________________________________________________

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*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. (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 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 ____________________________