

City of Torrance
Certification for Serious Injury or Illness of Covered Servicemember for
Military Family Leave

Section I. Employee/Covered Servicemember Information

1. Employee Name: _____ Servicemember Name: _____
2. Employee Relationship to Servicemember:
 Spouse Parent Son Daughter Next of Kin
3. Is the Covered Servicemember a current member of the Regular Armed Forces, the National Guard or Reserves?
 Yes No

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

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 Veteran 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. 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 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 check the appropriate box. You are:

- a DOD health care provider a VA health care provider a DOD TRICARE network authorized private health care provider a DOD non-network TRICARE authorized private health provider.

Telephone: () Fax: () e-mail :

Part B: MEDICAL STATUS

(1) Covered servicemember's medical condition is classified as (check the appropriate box):

- (VSI) Very Seriously Ill/Injured:** Illness/Injury is of such a severity that life is imminently endangered.
 (SI) Seriously Injured: Illness/Injury is of such severity that there is cause for immediate concern.
 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

(2) Was the condition for which the Covered Servicemember is being treated incurred in the line of duty on active duty?
 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:

Part C: Covered Servicemember's Need for Care by Family Member

(1) Will the covered servicemember need care for a single continuous period of time, including any time for treatment 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 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:

Physician Signature:

Date: / /