

**UNIVERSITY SYSTEM OF MARYLAND, BALTIMORE**  
**Paid Family & Medical Leave - CERTIFICATION FOR MILITARY CAREGIVE LEAVE**

**Serious Health Condition – Covered Service Member**

**Confidential Medical Record – Maintain Separately from Personnel File**

Return completed form to the employee. Do not send to the U.S. Department of Labor.

This certification is used to evaluate whether leave qualifies under the federal Family and Medical Leave Act (FMLA) for military caregiver leave. Military caregiver leave is evaluated under federal law and may not qualify for Maryland Paid Family and Medical Leave (PFML).

Approval and designation of leave are determined separately by the employer.

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**SECTION I – EMPLOYER**

Either the employee or the employer may complete this section.

The Family and Medical Leave Act (FMLA) allows an eligible employee to take up to twenty-six (26) workweeks of leave in a single 12-month period to care for a covered service member with a serious injury or illness. See 29 U.S.C. § 2612(a)(3); 29 C.F.R. § 825.310.

The employer must generally allow at least fifteen (15) calendar days for return of this certification unless not practicable despite diligent good faith efforts.

Employers must maintain medical certifications as confidential medical records.

Employee Name: \_\_\_\_\_

Employer Name: University System of Maryland

Date Certification Requested: \_\_\_\_\_

Certification Due Date (at least 15 calendar days): \_\_\_\_\_

Covered Service Member's Name: \_\_\_\_\_

Relationship to Employee:

- Spouse
- Parent
- Child
- Next of Kin

If next of kin, describe relationship: \_\_\_\_\_

Employee Job Title: \_\_\_\_\_

Employee's Regular Work Schedule: \_\_\_\_\_

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## SECTION II – HEALTH CARE PROVIDER / AUTHORIZED MEDICAL PROVIDER

Please complete all relevant parts and sign.

For purposes of military caregiver leave, a “serious injury or illness” means:

- In the case of a current member of the Armed Forces, an injury or illness incurred in the line of duty that may render the service member medically unfit to perform the duties of their office, grade, rank, or rating; or
- In the case of a veteran, a qualifying injury or illness as defined under 29 C.F.R. § 825.127.

Provider Name (Print): \_\_\_\_\_

Business Address: \_\_\_\_\_

Type of Practice / Specialty: \_\_\_\_\_

Telephone: \_\_\_\_\_ Fax: \_\_\_\_\_

Email (optional): \_\_\_\_\_

Are you:

- A Department of Defense health care provider
- A Veterans Affairs health care provider

- A DOD TRICARE network provider
  - A DOD non-network TRICARE provider
  - Other health care provider (as defined by FMLA)
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**PART A – MEDICAL STATUS OF COVERED SERVICE MEMBER**

1. Is the service member:

- A current member of the Armed Forces
- A veteran (discharged within the past 5 years)

2. Approximate date the serious injury or illness commenced: \_\_\_\_\_

3. Is the condition related to military service?

- Yes
- No

4. Is the injury or illness incurred in the line of duty?

- Yes
- No

5. Probable duration of condition: \_\_\_\_\_

6. Briefly describe the serious injury or illness:

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**PART B – NEED FOR CARE**

Is it medically necessary for the employee to provide care for the covered service member?

- Yes
- No

If yes, describe the care needed (e.g., assistance with daily living, medical transport, psychological support):

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Estimate the period during which care will be required:

From \_\_\_\_\_ To \_\_\_\_\_

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### **PART C – AMOUNT OF LEAVE NEEDED**

#### **Continuous Leave**

Is continuous leave medically necessary?

Yes

No

If yes, estimate:

From \_\_\_\_\_ To \_\_\_\_\_

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#### **Reduced Schedule Leave**

Is a reduced schedule medically necessary?

Yes

No

If yes, estimate:

From \_\_\_\_\_ To \_\_\_\_\_

Employee can work: \_\_\_\_\_

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#### **Intermittent Leave**

Is intermittent leave medically necessary?

Yes

No

Over the next six (6) months, episodes are estimated to occur:

\_\_\_\_\_ times per  day  week  month

Each episode likely to last approximately:

\_\_\_\_\_  hours  days

(Note: Military caregiver leave is evaluated under FMLA standards. PFML may not apply.)

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### HEALTH CARE PROVIDER CERTIFICATION

I certify that the information provided is true and complete to the best of my knowledge.

Signature: \_\_\_\_\_

Printed Name: \_\_\_\_\_

License Number (if applicable): \_\_\_\_\_

State of Licensure: \_\_\_\_\_

Date: \_\_\_\_\_

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### IMPORTANT NOTICE REGARDING ENTITLEMENT

Military caregiver leave allows up to twenty-six (26) workweeks of FMLA leave in a single 12-month period measured forward from the first day of military caregiver leave.

This 12-month period is separate from the 12-month period used for other types of FMLA leave.



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