Mashantucket Pequot Tribal Nation

MASHANTUCKET EMPLOYMENT RIGHTS OFFICE (MERO)

Certification of Health Care Provider for Veteran's Serious Injury or Illness

For leave under Title 51, the Mashantucket Pequot Family and Medical Leave Law (MFML Law)

The Mashantucket Pequot Family and Medical Leave Law (MFML Law) provides that eligible employees may take protected leave to care for a covered veteran with a serious illness or injury. The MFML Law allows an employer to require an employee seeking leave for this purpose to submit a medical certification. The employee must receive **at least 15 calendar days** from their receipt of the form to provide the completed certification. If the employee fails to provide a complete and sufficient certification, their leave request may be denied. Additional information about the MFML Law may be found at MERO.mptn-nsn.gov.

SECTION I – EMPLOYER OR EMPLOYEE

Either the employer or the employee may complete Section I. Use of this form is optional, but this form asks the health care provider for the information necessary for a complete and sufficient medical certification. Recertifications are not allowed for leave under the MFML Law to care for a covered veteran.

The employer may not ask the employee to provide more information than allowed under the MFML Law and regulations. Where a medical certification is requested by an employer, an employee may not be held liable for administrative delays in the issuance of military documents, despite the employee's diligent, good-faith efforts to obtain such documents. An employer requiring an employee to submit a certification for leave to care for a covered veteran **must** accept as sufficient certification of the veteran's serious injury or illness documentation indicating the veteran's enrollment in the Department of Veterans Affairs Program of Comprehensive Assistance for Family Caregivers.

Employers must generally maintain records and documents created for MFML Law purposes relating to medical information, medical certifications, recertifications, or medical histories of employees or employees' family members, as confidential medical records in separate files/records from the usual personnel files and in accordance with the strictest confidentiality requirements of applicable law.

EMPLOYEE NAME	**DATE CERTIFICATION REQUESTED**
EMPLOYER NAME	**DATE CERTIFICATION MUST BE RETURNED***
EMPLOYEE'S JOB TITLE	**EMPLOYEE IDENTIFICATION NUMBER**

*The employee must have at least 15 calendar days from the date they receive the form to return the completed certification. If return of the certification within 15 days is not feasible despite the employee's diligent, good faith efforts, additional time must be provided.

SECTION II– EMPLOYEE and/or VETERAN

Please complete all relevant parts of this Section II before having the veteran's health care provider complete Section III. An employer may require that the employee submit a timely, complete, and sufficient certification to support a request for leave under the MFML Law. If requested by your employer, your response is required to obtain or retain the benefit of protected leave under the Law.

PART A: EMPLOYEE INFORMATION

(1) Full Name of veteran for whom employee is requesting leave (*Please print or type*):

_____

(2) Select your relationship to the veteran by checking the box(es) that complete the sentence below.

I am the veteran's:

☐ **Spouse –** Partner by marriage or civil union that is legal in the jurisdiction in which it was performed.

☐ **Child (of any age) –** biological, adopted, or foster child, stepchild, TMDC*, legal ward, or a child to whom the servicemember now stands *in loco parentis*** or to whom the servicemember stood *in loco parentis*** when I was under the age of 18.

☐ **Grandchild –** Related by blood, marriage, my adoption by the servicemember's child, in foster care with the servicemember's child, or as a TMDC* of the servicemember's child.

☐ **Parent –** Biological parent, adoptive parent, stepparent, parent-in-law, foster parent, or legal guardian, or a

person standing *in loco parentis*** to the servicemember currently or when the servicemember was under the age of 18.

☐ **Grandparent -** Related to the servicemember by blood, marriage, adoption of the servicemember as a minor child by my child, foster care of the servicemember by my child, or the servicemember is a TMDC* of my child.

☐ **Sibling –** Biological, half, step, adopted or foster-sibling, sibling-in-law, or TMDC* sibling.

☐ **Next of Kin** - Nearest blood relative not identified above who ☐ the covered servicemember designated in writing; ☐ has legal custody of the covered servicemember; ☐ is an aunt, uncle, cousin or other blood relative.

***TMDC means Tribal Member Dependent Child -** a person who is not a member of the Mashantucket Pequot Tribal Nation (MPTN) who was in the custody and care of a member of MPTN and resided in the household of the Tribal Member as a member of their family for at least seven (7) years on or before reaching the age of 18.

****In loco parentis*** means a relationship in which a person assumes the obligations of a parent to a child, such as the day-to-day responsibilities to care for or financially support a child. No biological or legal relationship is required.

PART B: VETERAN INFORMATION AND CARE TO BE PROVIDED TO THE VETERAN

(1) The veteran was ☐ honorably ☐ dishonorably discharged or released from the U.S. Armed Forces, including the National Guard or Reserves. List the date of the veteran's discharge: _____ *(mm/dd/yyyy)*

(2) Please provide the veteran's military branch, rank and unit at the time of discharge: _____

_____

(3) The veteran ☐ is ☐ is not receiving medical treatment, recuperation, or therapy for an injury or illness

(4) Briefly describe the care you will provide to the veteran: *(Check all that apply)*

☐ Assistance with basic medical, hygienic, nutritional, or safety needs

☐ Psychological Comfort ☐ Physical Care ☐ Transportation

☐ Other: _____

(5) Give your **best estimate** of the amount of leave needed to provide the care described:

_____

(6) If a reduced work schedule is necessary to provide the care described, give your **best estimate** of the reduced work schedule you are able to work. From _____*(mm/dd/yyyy)* to _____ *(mm/dd/yyyy),* I am able to work: _____*(hours per day)* _____ (*days per week).*

SECTION III– HEALTH CARE PROVIDER

Please provide your contact information, complete all relevant parts of this Section III fully and completely, and sign the form below. The employee listed in Section I has requested leave under the MFML Law to care for a family member who is a veteran with a serious injury or illness.

Note: For purposes of the MFML Law Military Caregiver Leave, a serious injury or illness is one that was incurred in the line of duty on active duty in the U.S. Armed Forces or that existed before the beginning of the member's active duty and was aggravated by service in the line of duty on active duty in the U.S. Armed Forces and manifested itself before or after the servicemember became a veteran, and is: a continuation of a serious injury or illness that was incurred or aggravated when the covered veteran was a member of the U.S. Armed Forces and rendered the servicemember unable to perform the duties of the servicemember's office, grade, rank, or rating; or a physical or mental condition for which the covered veteran has received a U.S. Department of Veterans Affairs Service Related Disability Rating (VASRD) of 50 percent or greater, and such VASRD rating is based, in whole or in part, on the condition precipitating the need for military caregiver leave; or a physical or mental condition that substantially impairs the covered veteran's ability to secure or follow a substantially gainful occupation by reason of a disability or disabilities related to military service, or would do so absent treatment; or an injury, including a psychological injury, on the basis of which the covered veteran

has been enrolled in the U.S. Department of Veterans' Affairs Program of Comprehensive Assistance for Family Caregivers.

An eligible employee may take leave under the MFML Law if they are needed to care for the veteran, which includes both physical and psychological care. It includes situations where, for example, due to their serious injury or illness, the veteran is not able to care for their own basic medical, hygienic, or nutritional needs or safety, or needs transportation to the doctor. It also includes providing psychological comfort and reassurance that would be beneficial to the veteran who is receiving inpatient or home care.

A complete and sufficient certification to support a request for leave under the MFML Law due to a veteran's serious injury or illness includes written documentation confirming that the veteran's injury or illness was incurred in the line of duty on active duty or existed before the beginning of the veteran's active duty and was aggravated by service in the line of duty on active duty in the U.S. Armed Forces, and that the veteran is undergoing treatment, recuperation or therapy for such injury or illness by a health care provider listed herein. Information about the MFML Law may be found at MERO.mptn-nsn.gov.

PART A: HEALTH CARE PROVIDER INFORMATION (Please type or print legibly)

Health Care Provider's Name: _____

Health Care Provider's Business Address: _____

_____

Type of Practice/Medical specialty: _____

Telephone: (_____) _____Fax: (_____)_____

E-mail:_____

Please select the type of health care provider you are:

☐ DOD health care provider ☐ VA health care provider ☐ DOD TRICARE network authorized private health care provider ☐ DOD non-network TRICARE authorized private health care provider ☐ Health care provider as defined in the MERO's Title 51 regulations, available at MERO.mptn-nsn.gov.

PART B: MEDICAL INFORMATION

Please provide appropriate medical information of the patient as requested below. Limit your responses to the veteran's condition for which the employee is seeking leave. If you are unable to make some of the military-related determinations contained below, you are permitted to rely upon determinations from an authorized DOD representative, such as a DOD recovery care coordinator, or an authorized VA representative. Do not provide information about genetic tests, as defined in 29 C.F.R. §1635.3(f), or genetic services, as defined in 29 C.F.R. §1635.3(e).

(1) Patient's Name: _____

(2) List the approximate date condition started or will start: _____(*mm/dd/yyyy*)

(3) Provide your **best estimate** of how long the condition will last:_____

(4) The veteran's injury or illness: *(Select as appropriate)*

☐ Was incurred in the line of duty on active duty.

☐ Existed before the beginning of the veteran's active duty and was aggravated by service in the line of duty on active duty.

☐ None of the above.

(5) The veteran ☐ is ☐ is not undergoing medical treatment, recuperation, or therapy for this condition. If yes, briefly describe the medical treatment, recuperation or therapy: _____

_____

(6) The veteran's medical condition is classified as: (*Select as appropriate*)

☐ A continuation of a serious injury or illness that was incurred or aggravated when the covered veteran was a member of the U.S. Armed Forces and rendered the servicemember not able to perform the duties of the servicemember's office, grade, rank, or rating.

☐ A physical or mental condition for which the covered veteran has received a U.S. Department of Veterans Affairs Service Related Disability Rating (VASRD) of 50% or higher, and such VASRD rating is based, in whole or in part, on the condition precipitating the need for military caregiver leave.

☐ A physical or mental condition that substantially impairs the covered veteran's ability to secure or follow a substantially gainful occupation by reason of a disability or disabilities related to military service, or would do so absent treatment.

☐ An injury, including a psychological injury, on the basis of which the covered veteran is enrolled in the Department of Veterans' Affairs Program of Comprehensive Assistance for Family Caregivers.

☐ 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 the MFML Law. If such leave is requested, you may be required to complete MERO Form 51-6380 (Certification of Health Care Provider for Family Member's Serious Health Condition) or an employer-provided form seeking the same information.*

PART C: AMOUNT OF LEAVE NEEDED

For the medical condition checked in Part B, complete all that apply. Some questions seek a response as to the frequency or duration of a condition, treatment, etc. Your answer should be your **best estimate** based upon your medical knowledge, experience, and examination of the patient. Be as specific as you can; terms such as "*lifetime,*" "*unknown,*" or "*indeterminate*" may not be sufficient to determine military caregiver leave coverage under the MFML Law.

(1) Due to the condition, the veteran will need care for a **continuous period of time**, including any time for treatment and recovery. Provide your **best estimate** of the beginning date _____ *(mm/dd/yyyy)* and end date _____*(mm/dd/yyyy)* for this period of time.

(2) Due to the condition, it is medically necessary for the veteran to attend **planned medical treatment** appointments (scheduled medical visits). Provide your **best estimate** of the duration of the treatment(s), including any period(s) of recovery _____ *(e.g. 3 days/week)*

(3) Due to the condition, it is medically necessary for the veteran to receive care on an **intermittent basis** (periodically), such as the care needed because of episodic flare-ups of the condition or assisting with the veteran's recovery. Provide your **best estimate** of how often (frequency) and how long (the duration) the intermittent episodes will likely last.

Over the next six (6) months, intermittent care is estimated to occur _____times per ☐ day ☐ week ☐ month and are likely to last approximately _____ ☐ hours ☐ days per episode.

Health Care Provider Signature:_____ **Date**:_____*(mm/dd/yyyy)*

DO NOT SEND COMPLETED FORM TO THE MERO. RETURN FORM TO YOUR PATIENT.