

**Certification for Serious Injury or Illness
Of Covered Servicemember for Military Family Leave
(Family and Medical Leave Act)**



SECTION I: For Completion by the EMPLOYEE and/or the COVERED SERVICEMEMBER for whom The Employee Is Requesting Leave: (This section must be completed first before any of the below sections can be completed by a health care provider.)

PART A: EMPLOYEE INFORMATION

Name and Address of Employer (this is the employer of the employee requesting leave to care for covered servicemember):

Name of Employee Requesting Leave to Care for Covered Servicemember:

First	Middle	Last	Employee Number
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Name of Covered Servicemember (for whom employee is requesting leave to care):

First	Middle	Last
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Relationship of Employee to Covered Servicemember Requesting Leave to Care:

Spouse Parent Son Daughter Next of Kin

PART B: COVERED SERVICEMEMBER INFORMATION

(1) 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 & unit currently assigned to:

Is the covered servicemember 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 a medical hold or warrior transition unit)?

Yes No. If yes, please provide the name of the medical treatment facility or unit:

(2) Is the Covered Servicemember on the Temporary Disability Retired List (TDRL)? Yes No.

PART C: CARE TO BE PROVIDED TO THE COVERED SERVICEMEMBER

Describe the Care to Be Provided to the Covered Service member and an Estimate of the Leave Needed to Provide the Care:

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

Veterans Affairs ("VA") health care provider; (2) a DOD TRICARE network authorized private health care provider; or (3) a DOD non-network TRICARE authorized private health care 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 ensure that Section I above has been completed before completing this section.) Please be sure to sign the form.

PART A: HEALTH CARE PROVIDER INFORMATION

Health Care Provider's Name and Business Address:

Type of Practice/Medical Specialty: _____

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 health care provider; or (4) a DOD non-network TRICARE authorized private health care provider: _____

Telephone: () _____ Fax () _____ Email: _____

PART B: MEDICAL STATUS

- (1) Covered Servicemember'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. (Note this is an internal DOD casualty assistance designation used by the 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 servicemember 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 DOL FORM WH-380 or an employer-provided form seeking the same information.)
- (2) Was the condition for which the Covered Services member is being treated incurred in line of duty on active duty in the armed forces? 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 these follow-treatment appointments? Yes No

(4) 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 of the periodic care:

Signature of Health Care Provider: _____ **Date:** _____

ACS Family Medical Leave Policy Outline

Family Medical Leave Act (FMLA) requires covered employers to provide up to twelve (12) weeks of unpaid, job protected leave during a rolling twelve (12) month period to "eligible" employees for certain family and medical reasons and up to twenty-six (26) weeks of leave in a single twelve (12) month period to "eligible" employees for a covered servicemember. Employees are eligible if they have been employed by AMES for at least one (1) year and have worked 1,250 hours over the previous twelve (12) months.

REASONS FOR TAKING LEAVE: Unpaid leave must be granted for any of the following reasons:

- The birth of a child, or placement of a child with you for adoption or foster care.
- Your own serious health condition.
- Because you are needed to care for your spouse, child, or parent due to his/her serious health condition.
- Because of a qualifying exigency arising out of the fact that your spouse, son or daughter, or parent is on active duty or call to active duty status in support of a contingency operation as a member of the National Guard or Reserves.
- Because you are the spouse, son or daughter, parent, or next of kin of a covered servicemember with a serious injury or illness.

At the employee or employer's option, certain kinds of paid leave may be substituted for unpaid leave.

ADVANCE NOTICE AND CERTIFICATIONS: The employee may be required to provide advance leave notice and medical certification. Taking of leave may be denied if requirements are not met.

- The employee ordinarily must provide thirty (30) days advance notice when the leave is "foreseeable".
- Medical certification to support a request for leave because of a serious health condition is required within fifteen (15) calendar days of the Company's request.
- Certification to support a request for leave because of a qualifying military exigency is required within fifteen (15) calendar days of the Company's request.

JOB BENEFITS AND PROTECTION:

- For the duration of the FML, the employer must maintain the employee's health coverage under any "group health plan", provided employees pay their portion of the premium.
- You have a minimum 30-day grace period in which to make premium payments. If payment is not made timely, your group health insurance may be cancelled, provided we notify you in writing at least 15 days before the date that your health coverage will lapse.
- Upon return from FML, most employees must be restored to their original or equivalent positions with equivalent pay, benefits, and other employment terms.
- The use of FML cannot result in the loss of any employment benefit that accrued prior to the start of an employee's leave.

FML APPROVAL:

- FML is conditionally approved for eligible employees pending receipt of medical certification in accordance with the federal FMLA regulations. Failure to provide medical certification will cause the leave request to be denied or delayed and ACS attendance policies will apply.

HOW TO REQUEST FML:

- FML is requested by completing the FML Request Form and submitting it to the address below.
 - If the leave is planned, thirty days notice should be given. If unforeseeable/unplanned (e.g., medical emergency), notice must be given as soon as possible.
- Forms are located at the Communications Centers, at www.myabx.com or by contacting the HR Department.

INSURANCE PREMIUMS:

- Employees must pay their portion of any health or voluntary life insurance premiums.

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RETURN TO HUMAN RESOURCES (ILN 2061-B)