|  |  |  |
| --- | --- | --- |
| Name (Last, First, Middle Initial) | Employee ID | Date Submitted |
| Department | Date of Appointment with Health Care Provider | Time of Appointment with Health Care Provider |

**Treatment Verification for Disabled Veteran Leave**

A. Employee Information (To be completed by the employee)

I certify that I am requesting Wounded Warriors Leave in conjunction with a military service-connected disability rated at 30 percent or more. I have provide documentation to the Montgomery County Government Human Resources Department certification that I have a qualifying service-connected disability.

I also acknowledge that I have **3 calendar days** from the date I return to work to provide this verification to the appropriate supervisor to use Disabled Veteran Leave in lieu of sick leave, annual leave, or leave without pay.

|  |  |
| --- | --- |
| Employee Signature | Date |

**Privacy Act Statement:** Your information will be used to administer leave. Collection is authorized by 39 USC 401, 404, 1001, 1003, and 1005; and 29 USC 2601 et seq. Providing the information is voluntary, but if not provided, we may not process your request. Your information may be disclosed as follows: in relevant legal proceedings; to law enforcement when the MCG or requesting agency becomes aware of a violation of law; to a congressional office at your request; to entities under contract with MCG and/or authorized to perform audits; to labor organizations as required by law; to government agencies regarding personnel matters; to the EEOC; and to the MSPB or Office of Special Counsel/ For more information regarding our privacy policies visit [www.mcg.com/privacypolicy](http://www.mcg.com/privacypolicy)

B. Provider Information (To be completed by the health care provider)

|  |  |  |
| --- | --- | --- |
| Name of Physician/Provider | Specialty | |
| Name of Health Care Facility | | Contact Telephone Number |

Please provide details of any treatment required, including the frequency and/or duration of any course of action you may prescribe, that would necessitate the employee taking addition leave from work beyond the date of appointment identified in the *Employee information* portion of this verification form.

|  |
| --- |
|  |

The above-referenced employee is requesting to take leave under the Wounded Warriors Federal Leave Act of 2015 for treatment of a service-connected disability, as certified by the U.S. Department of Affairs. Treatment is defined as an in-person visit to a health care provider and includes the course of action prescribed by a health care provider. Your signature below, as the health care provider, verifies that the identified employee is undergoing treatment for a certified disabling condition.

|  |  |
| --- | --- |
| Health Care Provider Signature | Date |
| Printed Name | |
|  | |

C. Official Action on Application (Return copy of signed request to employee)

\_\_ Approved \_\_ Disapproved

Reason/Reason for disapproval (if applicable):

Human Resource Representative Signature Date