| 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 Disabled Veteran Leave in conjunction with a military service-connected disability rated at 30 percent (30%) or more. I have provided documentation to the Montgomery County Government (MCG) Human Resources Department certifying that I have a qualifying service-connected disability.

I also acknowledge that I have **three** (**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; however, 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.

## 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 additional leave from work beyond the date of appointment identified in the *Employee information* portion of this verification form.

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 for disapproval (if applicable):

**HR Representative Signature and Date of Determination:**

Signature Date