

5. Is the Covered Servicemember undergoing medical treatment, recuperation, or therapy? ___No___Yes, 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 continuous period of time, including any time for treatment and recovery? ___No___Yes, if yes, estimate the beginning and ending dates for this period of time: _____

2. Will the Covered Servicemember require periodic follow-up treatment appointments? ___No___Yes, if yes, estimate the treatment schedule: _____

3. Is there a medical necessity for the Covered Servicemember to have periodic care for these follow-up treatment appointments? ___No___Yes

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)? ___No___Yes, if yes, please estimate the frequency and duration of the periodic care: _____

Signature of Health Care Provider

Date

Return Completed Form to: Lamar University/Lamar Institute of Technology Human Resources Office
PO Box 11127 Beaumont, TX 77710 or Fax to (409) 880-8464