INDIANA UNIVERSITY

Medical Certification for FAMILY
FMLA - Form #2F

SECTION 1: To be completed by the EMPLOYEE:

Name of Employee (Print): _____

Employee Contact Information: _____ (phone) _____ (email)

My regular work hours/schedule is: _____ (days of the week) to _____ from _____ a.m./p.m. to _____ a.m./p.m.

I ❑ authorize ❑ do not authorize (check one) the health care provider identified below to provide the information requested on this form for the purpose of determining if I qualify for an FMLA leave and for a designated IU human resources professional to contact the health care provider to authenticate and/or clarify the information, if needed. I understand that if I do not agree to this authorization, my FMLA leave request could be delayed or denied.

Employee's Signature: _____ Date: _____

An employee who fraudulently obtains FMLA leave will be subject to disciplinary action, up to and including termination.

Name and relationship of family member needing your care: _____

If family member is your child or same sex domestic partner's child, provide the date of birth of the child: _____

Describe the care you will provide to your family member and estimate time needed to provide care: _____

SECTION 2: To be completed by the HEALTH CARE PROVIDER only:

Instructions to the Health Care Provider: A family member of your patient has indicated a need for leave under the FMLA. Answer fully and completely ALL applicable parts. Give your **best estimate** as answers, based on your medical knowledge and experience. "Unknown" or "indeterminate" is not sufficient to determine FMLA coverage. Limit your response to the condition for which the patient needs care. Failure to provide sufficient information may cause the employee's FMLA request to be delayed or denied.

Part A: Medical Facts:

Approximate date condition began: _____ Probable duration: _____

Mark below as applicable:

1. Was the patient admitted for an overnight stay in the hospital, hospice, or residential medical care facility? ❑ Yes ❑ No
   If yes, date(s) of admission: _____
2. Date(s) you have treated the patient for this condition: _____
3. Will the patient need to have treatment visits at least twice per year due to the condition? ❑ Yes ❑ No
4. Was medication other than over-the-counter medication, prescribed? ❑ Yes ❑ No
5. Is your patient reliant on others for transportation for medical care? ❑ Yes ❑ No
6. Was the patient referred to other health care provider(s) for evaluation or treatment (e.g. physical therapist)? ❑ Yes ❑ No
   If yes, state the nature of such treatments, expected duration of treatment, and the name of the other medical provider:

   _____

   _____
7. Is the medical condition due to pregnancy complications of the spouse or qualified same sex domestic partner?
   ❑ Yes ❑ No If yes, expected delivery date: _____

8. Describe relevant medical facts related to the condition for which the patient needs care (such medical facts may include symptoms, diagnosis, or any regimen of continuing treatment): _____

Part B: Amount of Leave Needed: (Please answer the following questions based on the employee's work hours and schedule – in Section 1 of this form.)

1. Will the patient be incapacitated for a single continuous period of time including any time for treatment and recovery during the hours the employee works? ❑ Yes ❑ No

   a. During this time, will the patient need care during the hours the employee works? ❑ Yes ❑ No If yes, estimate the beginning and ending dates for the period of incapacity: _____
   If yes, explain the care and why such care is medically necessary: _____

2. Will the patient require care due to follow-up treatment appointment(s) including time for recovery during the hours the employee works? ❑ Yes ❑ No

   a. If any, estimate treatment schedule including the dates of scheduled appointments and the time required for each appointment, including any recovery period: _____

   b. Will the patient require care on an intermittent or reduced schedule basis including time for recovery during the hours the employee works? ❑ Yes ❑ No
   If yes, please estimate the hours the patient needs care on an intermittent basis, if any:
   _____ # Hour(s) per day _____ # Day(s) per week or _____ # Days(s) per month From _____ through _____
   (Date) (Date)
   If yes, explain the intermittent care and why such care is medically necessary: _____

3. Will the condition cause episodic flare-ups which prevent the patient from participating in normal daily activities? ❑ Yes ❑ No

   a. Based upon the patient's medical history and your knowledge of the medical condition, estimate the frequency of flare-ups and the duration of related incapacity that the patient may have (e.g. an episode every 3 months lasting 1 day):
   Frequency: _____ # times per ❑ week or ❑ month

   For: _____ # hours or _____# day(s) per episode

   From: _____ (date) to _____ (date)

   b. Does the patient need care during these flare-ups? ❑ Yes ❑ No
   If yes, explain the care and why such care is medically necessary: _____

GINA Notification to Health Care Providers: The Genetic Information Nondiscrimination Act of 2008 (GINA) prohibits employers and other entities covered by GINA Title II from requesting or requiring genetic information of employees or their family members. In order to comply with this law, we are asking that you not provide any genetic information when responding to this request for medical information. 'Genetic information,' as defined by GINA, includes an individual's family medical history, the results of an individual's or family member's genetic tests, the fact that an individual or an individual's family member sought or received genetic services, and genetic information of a fetus carried by an individual or an individual's family member or an embryo lawfully held by an individual or family member receiving assistive reproductive services.

Signature of Health Care Provider: _____ Date: _____

Printed name of Health Care Provider: _____

Type of Practice/Medical specialty: _____

Contact information of Health Care Provider: _____
(Address)

_____
(Phone number) (Fax) (Email address)