INDIANA UNIVERSITY

Family Medical Leave Act (FMLA)
FORM #2F–Medical Certification for Family

HUMAN RESOURCES

IMPORTANT INFORMATION—PLEASE READ BEFORE COMPLETING THIS FORM

Please type or print all information legibly. Once fully completed, Return to your Department Head or Supervisor. Further information on FMLA Policy & Procedures, including the terms and conditions of FMLA can be found at **hr.iu.edu/relations/fmla_index.html**. NOTE: An employee who fraudulently obtains FMLA leave will be subject to disciplinary action, up to and including termination.

SECTION 1 To be Completed by EMPLOYEE

Employee Name:	**10-Digit University ID:**
E-Mail Address:	**Phone:**

My Regular Work Hours/Schedule is: ______________ through ________________ from ___________ am / pm to _____________am / pm
(day of week) (day of week) (time) (time)

Name of Family Member in need of your care:

Relationship to Employee: ❑ Spouse ❑ Child Under 18 ❑ Child 18 or Older ❑ Parent ❑ Other:

If family member is your child, provide the child's date of birth:

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

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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 Signature: ____ **Date:** ____________________

SECTION 2 To be Completed by 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.) **Dates 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/treatment (e.g. physical therapy)?** ❑ Yes ❑ No If yes, state the nature of such treatments, expected duration of treatment, and the name of other medical provider: ______________________

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7.) **Is the medical condition due to complications of pregnancy?** ❑ Yes ❑ No If yes, expected delivery date: ____________________

(Continued Reverse Side)

SECTION 2 To be Completed by **HEALTH CARE PROVIDER ONLY** (continued)

8.) **Describe facts such as symptoms, diagnosis, or any regimen of continuing treatment related to the condition for which the patient needs care**: ____

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PART B: AMOUNT OF LEAVE NEEDED (Answer the following questions based on the employee's work hours & schedule in Section 1 of this form)

1.) **Will the patient be incapacitated for a single continuous period of time due to his/her medical condition including any time for treatment/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: ______________ to ______________

If yes, explain the care and why such care is medically necessary: ______________________________

____

2.) **Will patient require care for follow-up treatment, including recovery time, during employee's work hours?** ❑ 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 basis including time for recovery during the hours the employee works? ❑ Yes ❑ No

If yes, estimate the hours the patient needs care on an intermittent basis, if any: ________ Hours per day ________ Days per week

From (date) ______________ through (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 on the patient's medical history and your knowledge of the medical condition, estimate frequency of flareups and the duration of incapacity that patient may have (e.g. 1 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:

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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.

Printed Name of Health Care Provider: ____

Signature of Health Care Provider: ______________________________ **Date**: ______________

Type of Practice/Medical Specialty: ____

Provider Contact Information:

Street Address:		City:	State:	Zip Code:
Phone:	Fax:	E-Mail Address:		