INDIANA UNIVERSITY

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

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**

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

My Regular Work Hours/Schedule is: _____ (day of week) through _____ (day of week) from _____ (time) AM. to _____ (time) PM.

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 **DEPARTMENT**

Is an *Intent to Return and Fitness for Duty/Medical Release (Form 3)* required prior to the employee's return to work? ☐ Yes ☐ No

If yes, an *Essential & Marginal Job Functions Worksheet* is attached (REQUIRED for Serious Health Conditions): ☐ Yes ☐ No

(Both forms available at **hr.iu.edu/pubs/forms/forms-list.htm#fmla**)

SECTION 3 To be Completed by **HEALTH CARE PROVIDER ONLY**

Instructions to the Health Care Provider: Your patient has indicated a need for leave under the FMLA. Answer fully and completely ALL applicable parts. Your answer should be your best estimate based on your medical knowledge and experience. "Unknown" or "indeterminate" is not sufficient to determine FMLA coverage. Limit your responses to the condition for which the employee is seeking leave. 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.) **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: _____

_____

_____

6.) **Is the medical condition due to complications of pregnancy?** ☐ Yes ☐ No If yes, expected delivery date: _____

Comments: _____

(Continued Reverse Side)

SECTION 3 To be Completed by **HEALTH CARE PROVIDER ONLY** (continued)

Answer questions 7 & 8 if an *Essential & Marginal Job Functions Worksheet* is attached.

7.) **Is the employee unable to perform any of his/her essential job functions due to the condition?** ☐ Yes ☐ No If yes, identify the essential job functions the employee is **unable** to perform: _____

_____

8.) **Describe relevant facts such as symptoms, diagnosis, or any regimen of continuing treatment related to the condition for which the employee needs leave from their job**: _____

_____

_____

PART B: AMOUNT OF LEAVE NEEDED

1.) **Will the employee be incapacitated for a single continuous period of time due to his/her medical condition including any time for treatment/recovery?** ☐ Yes ☐ No If yes, estimate the begin/end dates for the continuous period of incapacity: _____

_____

2.) **Will it be medically necessary for the employee to have follow-up treatments?** ☐ Yes ☐ No

3.) **If applicable, estimate time(s) needed for treatments, appointments, and recovery**: _____

_____

4.) **Is it medically necessary for the employee to work part-time or a reduced work schedule?** ☐ Yes ☐ No If yes, please estimate:

_____ Hour(s) per day off work _____ Day(s) per week off work **From** (date) _____ through (date) _____

5.) **Will the condition cause episodic flare-ups which prevent the employee from performing his/her job functions?** ☐ Yes ☐ No If yes, is it medically necessary for employee to be absent from work during these flare-ups? ☐ Yes ☐ No If yes, explain: _____

_____

_____

6.) **Based on the patient's medical history and your knowledge of the medical condition, estimate the frequency of flareups and the duration of incapacity the 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)

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:

Copy Distribution: (1) Original to your campus Human Resources office (2) copy to department (3) copy to employee.