

**Indiana University FMLA Form #2F**  
**FMLA Medical Certification for FAMILY**

---

---

**This section to be completed by the EMPLOYEE:**

Name of Employee (Print): \_\_\_\_\_

Job Title: \_\_\_\_\_ Leave Period: \_\_\_\_\_

Department: \_\_\_\_\_ Campus: \_\_\_\_\_

Reason for Leave: \_\_\_\_\_

Family Member's Name: \_\_\_\_\_

I hereby authorize the health care provider to release the following medical information for the purpose of determining compliance with the *Family and Medical Leave Act*.

Employee's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

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

---

---

**This section to be completed by the HEALTH CARE PROVIDER:**

**Certification of Health Care Provider (Family and Medical Leave Act of 1993):**

Patient's Name: \_\_\_\_\_

\_\_\_\_\_  
(Signature of Health Care Provider)

\_\_\_\_\_  
(Type of Practice)

\_\_\_\_\_  
Printed name of Health Care Provider

\_\_\_\_\_  
(Address)

\_\_\_\_\_  
(Phone number)

\_\_\_\_\_  
(Date)

---

The following information relates only to the condition for which the employee is taking FMLA covered leave.

**This page to be completed by the HEALTH CARE PROVIDER for:**  
**the health condition of a**  
**FAMILY MEMBER of the employee**

---

---

**Please complete or check ALL that apply:**

**ALL questions must be answered and all information completed for FMLA approval to be granted.**

Start date of condition: \_\_\_\_\_

**Serious Health Condition Type Category**    1\_\_ 2\_\_ 3\_\_ 4\_\_ 5\_\_ 6\_\_  
(See **attached** *FMLA Definition of Serious Health Conditions* for criteria)

As FMLA certification, **briefly DESCRIBE the medical facts** and state how the medical facts meet the criteria of an FMLA qualifying serious health condition:

\_\_\_\_\_

\_\_\_\_\_

Is the patient/family member in need of the employee to provide **basic medical or personal needs or safety**, or for **transportation** for serious health condition?

Yes    No

Would the employee's presence to provide **psychological comfort** be beneficial to the patient/family member or assist in the patient's recovery from serious health condition?

Yes    No

---

---

**Statements given below of "unknown" will be returned for clarification. PLEASE give time estimates.**

Does the employee **currently** need to be absent from work full time for this need?    Yes    No

If **yes**, for how long of a time period? \_\_\_\_\_

If **no**, and the patient will need care only *intermittently or on a part-time basis*, please indicate below (i.e., How often and for what periods of time will the employee likely to be absent from work for the care or comfort of the patient/family member?):

How long will the intermittent or part time schedule likely be necessary? \_\_\_\_\_

How often will the care likely cause the employee to be absent from work? (e.g., estimated # of days per wk/mon/yr?) \_\_\_\_\_

---

---

Signature of Health Care Provider \_\_\_\_\_ (Date) \_\_\_\_\_

# FMLA Definition of Serious Health Conditions

Based on guidelines from the U.S. Department of Labor

<u>TYPE</u>	<u>QUALIFYING CRITERIA</u>	<u>EXAMPLES</u>
1. Hospitalization and Subsequent Treatment	INCAPACITY* INVOLVING AN OVERNIGHT STAY IN A HOSPITAL OR RESIDENTIAL MEDICAL CARE FACILITY	Hospitalization for surgery Post-surgery doctor's exam Post-surgery physical therapy sessions
2. Pregnancy and Prenatal Care	ANY PERIOD OF INCAPACITY No other qualifications  A doctor's visit during the absence is <i>not</i> required.	Morning sickness  Doctor's visit for prenatal care
3. Chronic Conditions	ANY PERIOD OF INCAPACITY due to a chronic condition which: <ol style="list-style-type: none"> <li>1. Requires periodic visits for treatment</li> <li>2. Continues over an extended period of time</li> <li>3. May cause episodic rather than continuous incapacity</li> </ol> A doctor's visit during each absence is <i>not</i> required.	Asthma, diabetes, epilepsy, migraine headaches
4. Conditions Requiring Multiple Treatments	ANY PERIOD OF INCAPACITY for restorative surgery or for conditions that if left untreated would result in incapacity of more than 3 consecutive calendar days.	Chemotherapy or radiation for cancer Dialysis for kidney disease Physical therapy for arthritis
5. Permanent/Long Term Conditions	ANY PERIOD OF INCAPACITY. Individual must be under the continuing supervision of a doctor.	Alzheimer's, stroke, terminal diseases
6. Other Health Conditions	INCAPACITY MUST BE FOR MORE THAN 3 CONSECUTIVE CALENDAR DAYS <b><u>AND</u></b>  <ol style="list-style-type: none"> <li>1. Involves treatment 2 or more times by a health care provider</li> </ol> <p style="text-align: center;"><b>OR</b></p> <ol style="list-style-type: none"> <li>2. Involves treatment 1 time by a health care provider followed by a continuing regimen of treatment</li> </ol>	(Not <i>normally</i> included: common cold, flu, earache, routine dental problems)  Physical therapy sessions ordered by a doctor for a broken leg  A visit to doctor followed by course of prescription antibiotics

This fact sheet is for general information and is not to be considered in the same light as official statements of position contained in the regulation.

\***Incapacity**: inability to work, attend school, or perform other regular daily activities due to the SHC, treatment therefore, or recovery therefrom.