PERNR:_____ Org. Unit:_____

FMLA Medical Certification Form

A complete medical certification is required to determine whether your health condition, or the health condition of your Spouse, Son or Daughter or Parent, qualifies for leave under FMLA regulations.

Instructions to Employee: Complete Sections I and II. If you are requesting leave to care for your Spouse, Son, Daughter or Parent who has a Serious Health Condition, also complete Section III. Your health care provider or your family member's health care provider must complete Sections IV through IX. **It is your responsibility to ensure that the health care provider completes this form and returns it to the appropriate address within 15 calendar days.**

Instructions to Health Care Provider: Your patient or a family member of your patient has requested a Family and Medical Leave. In order for us to verify that this qualifies under the FMLA, please complete Sections IV through IX of this form, and return it within 15 calendar days of receipt to the appropriate contact listed below:

WEST LAFAYETTE EMPLOYEES:

Purdue University
Human Resources - Service Center (HRSC)
KURZ Purdue Technology Center(KPTC)
1281 Win Hentschel Blvd, Ste. 1100
West Lafayette, IN 47906-4182
Phone: (765) 494-2222

FAX: (765) 494-6720

REGIONAL EMPLOYEES:

Purdue University
Calumet
Human Resources
Schneider Ave Building Rm 1008
2200 169th Street
Hammond, IN 46323-2094
Phone: (219) 989-2251
FAX: (219) 989-2185

Indiana University Purdue University **Fort Wayne**
Human Resources
2101 Coliseum Boulevard East
Fort Wayne, IN 46805
Phone: (260) 481-6684
FAX: (260) 481-4164

Purdue University
North Central
Human Resources
1401 South U.S. Highway 421
Westville, IN 46391
Phone: (219) 785-5301
FAX: (219) 785-5540

To be Completed By Employee

Section I – Patient Information (Printed)

Employee's Name: _____

Patient's Name: _____

Relationship to Employee (if son or daughter, list date of birth): _____

Section II – Employee Signature

I permit Purdue University Human Resources or its designated Health Care Provider/third party administrator to contact my Health Care Provider or my family member's Health Care Provider for purposes of obtaining clarifying information and authenticity of the medical certification, if necessary.

_____ _____

Employee Signature **Date**

Section III – Care for Family Member (Printed)

State the care you will provide for your family member (if designated above).

_____

_____

_____

To Be Completed By Health Care Provider

Section IV – Patient Information

1. **Employee's Name:** _____
2. **Patient's Name:** _____
3. **Patient's relationship to employee (check one):**

☐ Self ☐ Spouse
☐ Son or Daughter ☐ Parent

Section V – Designation of Serious Health Condition

4. **Under FMLA a "Serious Health Condition" means an illness, injury, impairment, or physical or mental condition that involves one or more of the categories below. Does the patient's condition for which he/she is requesting FMLA leave qualify under any of the categories described? (Definitions on page 3.) If so, check the applicable category(ies):**

☐ Inpatient Care *(Overnight stay in hospital, hospice, or residential medical care facility)*
☐ Continuing Treatment *(Patient is unable to work or perform other regular daily activities for more than three consecutive, full calendar days and needs treatment)*
☐ Pregnancy
☐ Chronic Serious Health Condition *(i.e., asthma, diabetes, epilepsy, etc.)*
☐ Permanent/Long-term Condition Requiring Supervision *(i.e., Alzheimer's, severe stroke, terminal stages of disease)*
☐ Multiple Treatments *(i.e., for cancer, severe arthritis, kidney disease, etc.)*
☐ Not a serious health condition (proceed to Section IX)

5. **What are the medical facts supporting your certification in Question 4?**

_____

_____

_____

Section VI – Duration of Incapacity and Treatments

6. **State the approximate date the condition commenced:**

_____

7. **Estimate the probable duration of condition:**

_____ to _____

8. **Nature and estimated duration of treatment prescribed:**

_____

_____

Section VII – Employee Work Status (own condition)

Complete Question 9 only when employee needs to take leave because of employee's own serious health condition. Please provide specific information (i.e. 2 hrs. per day, twice per week for therapy appts. etc.)

9. **Because of the condition identified in questions 4 and 5, it is medically necessary for employee to:**

☐ Take a leave of absence on consecutive days from

_____ to _____

☐ Take intermittent leave according to the following schedule:

_____

_____.

☐ Work less than employee's normal schedule of hours per day or days per week according to the following schedule:

_____

_____

Section VIII – Employee Work Status (care for family)

Complete Questions 10 & 11 only when employee needs to take leave to care for patient who is a family member with a serious health condition. Please provide specific information(i.e. 2 hrs per day, twice per week for therapy appts, etc)

10. **Because of the condition identified in questions 4 and 5, employee needs a leave of absence to:**

☐ Assist patient with basic medical needs, hygiene/nutritional needs or for safety or transportation purposes.

☐ Provide psychological comfort that would be beneficial to patient or assist in patient's recovery.

11. **Identify the duration and schedule of time needed by employee to care for patient:**

_____

_____

_____

Section IX – GINA Information

The Genetic Information Nondiscrimination Act of 2008 ("GINA") prohibits employers from requesting or requiring genetic information of an individual or family member of the individual, except as specifically allowed by this law. 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.

Section X – Physician Information

Name of Health Care Provider (please print): _____

Provider's Signature: _____ **Date:** _____

Type of Practice: _____

Address: _____

Telephone Number: _____ **Fax Number:** _____

An illness, injury, impairment, or physical or mental condition that involves:

a) Inpatient care (i.e., an overnight stay) in a hospital, hospice, or residential medical care facility, including any period of incapacity (for purposes of this policy, defined to mean inability to work, attend school, or perform other daily regular activities due to the Serious Health Condition, treatment therefore, or recovery there from), or any subsequent treatment in connection with such inpatient care; or

b) Continuing treatment by a Health Care Provider.

A Serious Health Condition involving continuing treatment by a Health Care Provider includes any one or more of the following:

- A period of incapacity and treatment (i.e., inability to work, attend school, or perform other regular daily activities due to the Serious Health Condition, treatment therefore, or recovery therefrom) of more than three consecutive, full calendar days, including any subsequent treatment or period of incapacity relating to the same condition, that also involves:
  1. Treatment two or more times within 30 days of the first day of incapacity, unless extenuating circumstances exist, by a Health Care Provider, by a nurse or physician assistant under direct supervision of a Health Care Provider, or by a provider of health care services (e.g., physical therapist) under orders of, or on referral by, a Health Care Provider; or
  2. Treatment by a Health Care Provider on at least one occasion, which results in a regimen of continuing treatment under the supervision of the Health Care Provider.

  The treatment referenced in paragraphs (1) and (2) must be in-person visits to a Health Care Provider. The first (or only) in-person treatment visit must take place within seven days of the first day of incapacity.

- Any period of incapacity due to pregnancy or for prenatal care.

- Any period of incapacity or treatment for such incapacity due to a chronic Serious Health Condition. A chronic Serious Health Condition is one that:
  1. Requires periodic visits (defined as at least twice a year) for treatment by a Health Care Provider, or by a nurse or physician assistant under direct supervision of a Health Care Provider;
  2. Continues over an extended period of time (including recurring episodes of a single underlying condition); and
  3. May cause episodic rather than a continuing period of incapacity (e.g., asthma, diabetes, epilepsy, etc.)

- A period of incapacity that is permanent or long-term due to a condition for which treatment may not be effective. The Eligible Employee or Family Member must be under the continuing supervision of, but need not be receiving active treatment by, a Health Care Provider. Examples include Alzheimer's, a severe stroke, or the terminal stages of a disease.

- Any period of absence to receive multiple treatments (including any period of recovery therefrom) by a Health Care Provider or by a provider of health care services under orders of, or on referral by, a Health Care Provider, either for restorative surgery after an accident or other injury or for a condition that would likely result in a period of incapacity of more than three consecutive, full calendar days in the absence of medical intervention or treatment. Examples include cancer (chemotherapy, radiation, etc.), severe arthritis (physical therapy), or kidney disease (dialysis).

For the purposes of this definition, treatment includes, but is not limited to, examinations to determine if a Serious Health Condition exists and evaluations of the condition. Treatment does **not** include routine physical examinations, eye examinations, or dental examinations. A regimen of continuing treatment may include, for example, a course of prescription medication. A regimen of continuing treatment that includes the taking of over-the-counter medications, such as aspirin or antihistamines, or bed rest, exercise, or other similar activities that can be initiated without a visit to a Health Care Provider, is not, by itself, sufficient to constitute a regimen of continuing treatment for purposes of FMLA leave.

Examples of conditions that do not meet the definition of a Serious Health Condition and do not qualify for FMLA leave include:

- Conditions for which cosmetic treatments are administered (such as most treatments for acne or plastic surgery), unless inpatient hospital care is required or unless complications develop.
- Ordinarily, unless complications arise, the common cold, the flu, ear aches, upset stomach, ulcers, headaches other than migraine, routine dental or orthodontia problems, etc..

Substance abuse may be a Serious Health Condition if the conditions of this section are met. However, FMLA leave may only be taken for treatment for substance abuse by a Health Care Provider or by a provider of health care services on referral by a Health Care Provider. Absence because of the Eligible Employee’s use of the substance, rather than for treatment, does not qualify for FMLA leave.

Absences attributable to incapacity due to pregnancy or a chronic Serious Health Condition may qualify for FMLA leave even though the Eligible Employee or the Covered Family Member does not receive treatment from a Health Care Provider during the absence, and even if the absence does not last more than three consecutive, full calendar days. For example, an Eligible Employee with asthma may be unable to report for work due to the onset of an asthma attack or because the Eligible Employee’s Health Care Provider has advised the employee to stay home when the pollen count exceeds a certain level. An Eligible Employee who is pregnant may be unable to report to work because of severe morning sickness.