TMCC
Truckee Meadows Community College
Human Resources

MEDICAL CERTIFICATION FOR FAMILY

FMLA – Form # 2F

The Federal Family and Medical Leave Act (FMLA) entitles eligible employees of covered employers to take unpaid, job-protected leave for specified family and medical reasons with continuation of group health insurance coverage under the same terms and conditions as if the employee had not taken leave.

SECTION 1: TO BE COMPLETED BY THE EMPLOYEE

Name	Job Title	Employee ID

Address	City	State	Zip

Telephone	Email

Regular Work Hours

Days of the Week	Hours of the Day
To	From: _____ ☐ a.m. ☐ p.m. To: _____ ☐ a.m. ☐ p.m.

Authorization

I ☐ authorize ☐ do not authorize (check one) 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 TMCC 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.

Name of Family Member Needing Care	Relationship of Family Member to You	If family member is your 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

Signature

Employee Signature	Date

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

SECTION 2: TO BE COMPLETED BY THE HEALTH CARE PROVIDER

Instructions to the Health Care Provider: A family member of your patient has requested leave under the FMLA. Answer fully and completely all applicable parts. Several questions seek a response as to the frequency or duration of a condition, treatment, etc. Your answer should be your best estimate based on your medical knowledge, experience and examination of the patient. Be as specific as you can; terms such as "lifetime", "unknown" or "indeterminate" may not be 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. Please be sure to sign the form on the last page. Once completed, this form can be returned to family member, patient or faxed to TMCC's Human Resources Office at 775-674-7560.

Name of Health Care Provider (*print*)	Type of Practice/Medical Specialty

Email	Telephone	Fax

Address	City	State	Zip

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 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.*

PART A: MEDICAL FACTS

Approximate Date Condition Began	Probable Duration

Mark Below as Applicable

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:

Date(s) you treated the patient for this condition:

Will the Patient need to have treatment visits at least twice per year due to the condition? ☐ Yes ☐ No	Was medication, other that over-the-counter medication prescribed? ☐ Yes ☐ No

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:

Is the medical condition due to pregnancy? ☐ Yes ☐ No If "Yes", state the expected delivery date:

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

Will the patient be incapacitated for a single continuous period of time due to his/her medical condition including any time for treatment and recovery? ☐ Yes ☐ No	During this time will the patient need care? ☐ Yes ☐ No If "Yes", estimate the beginning and ending dates for the period of incapacity:

Explain the care and why such care is medically necessary:

Will the Patient require follow-up treatment appointment(*s*) including time for recovery? ☐ Yes ☐ No

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

Will the patient require care on an intermittent or reduced schedule basis including time for recovery? ☐ Yes ☐ No

If "Yes", please estimate the hours the patient needs care on an intermittent basis, if any:

Days of the Week: To Hours of the Day: From:_____ ☐a.m. ☐ p.m. To:_____ ☐a.m. ☐ p.m.

Explain the intermittent care and why such care is medically necessary:

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

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 over the next 6 months (*e.g., an episode every 3 months lasting 1 day*)

Frequency: time per week(*s*) month(*s*) Duration: hours or day(*s*) per episode

Does the patient need care during these flare-ups? ☐ Yes ☐ No If "Yes", explain the care and why such care is medically necessary.

Health Care Provider's Signature **Date**