UNIVERSITY of WASHINGTON
HUMAN RESOURCES

(not for HMC or UWMC staff)

Family and Medical Leave
Health Care Provider Certification for Parental Leave for Parent Other than the Birth Mother

Return the completed form as soon as possible, but no later than 15 calendar days after the date you receive it to:

Campus HR Operations & Services

Roosevelt Commons West
Box 354963
4300 Roosevelt Way NE
Seattle, WA 98195-4963
Fax: (206) 685-0636
Email: hrleaves@uw.edu

PART 1 – Employee Information: *To Be Completed by Employee*

Employee name:	EID:	Employee phone:	Employee email:
Birth Mother Name:	Department:	Supervisor's name:	

I am requesting continuous time off work ◯ No ◯ Yes

From (date) through

I am requesting a reduced work schedule as follows ◯ No ◯ Yes

hours/day for days/week until (date)

I am requesting an intermittent work schedule ◯ No ◯ Yes
If yes, describe requested schedule:

I am requesting Parental Shared Leave:
◯ No ◯ Yes

Employee Signature:

_____ Date:

PART 2 – Medical Facts: *To Be Completed by Health Care Provider, Adoption Agency or Foster*

Our employee is requesting time off from work or a modified work schedule under the FMLA as the parent (other than the birth mother) of a newborn child, or of a newly placed, adopted, or foster child. Please provide the information requested below.

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.

To be completed by Health Care Provider for Birth Mother

Expected date of baby's delivery:

Birth Mother's Health Care Provider Information (please complete or attach business card)
Provider Name:

Business Address: Phone:

Health Care Provider Signature

_____ Date:

To be completed by Adoption or Foster Care Agency for Adoptive or Foster Parent

Anticipated date of adoption or of becoming a foster parent:

Agency Information (please complete or attach business card)
Name of Agency or Organization: Agent Name (please print):

Business Address: Phone:

Agent Signature:

_____ Date: