UNIVERSITY of WASHINGTON
HUMAN RESOURCES

(not for HMC or UWMC staff)

Family and Medical Leave
Health Care Provider Certification for Family Member's Serious Health Condition

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:
Department:	**Family Member (Patient) Name and relationship to you:**		
Supervisor's name:		If a child, the child's date of birth:	

Describe the care you will provide and estimate the amount and/or frequency of leave needed. Please be as specific as possible regarding your need for leave. Examples: "up to 3 mornings or afternoons per month to take my mother to health care appointments" or "1 week to care for my son following surgery" – please print.

Employee Signature:

_____ Date:

PART 2 – Medical Facts: *To Be Completed by Health Care Provider*

Our employee is requesting leave from work and/or a modified work schedule under the Family and Medical Leave Act (FMLA) to care for a family member who is your patient. Please provide the information requested below so that we can process our employee's leave request. Only provide information regarding the condition(s) that relate to your patient's need for care from another person.

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.

Describe the medical facts related to your patient's condition(s) that require care from another person (medical facts may include symptoms, diagnosis, or any plan for continuing treatment or therapy)

Approximate date condition(s) began:	Probable duration of condition(s) (days, weeks, months):

Was your patient admitted for an overnight stay in a hospital, hospice, or residential medical care facility? ◯ No ◯ Yes
If yes, dates of admission:

Will your patient need to have treatment visits at least twice per year due to the condition? ◯ No ◯ Yes

Was medication, other than over-the-counter medication, prescribed? ◯ No ◯ Yes

Was your patient referred to other health care provider(s) for evaluation or treatment? ◯ No ◯ Yes
If yes, describe the nature and expected duration of the treatments:

Revised 3/19/2018

PART 3 – Requirements for Care: *To Be Completed by Health Care Provider*

Several of the following questions ask about the frequency or duration of a condition or treatment. We know that health conditions can vary or change over time, so please provide your best estimate in response to these questions, being as specific as you can. Using terms such as "lifetime," "unknown," or "as needed" may not be specific enough for us to determine leave eligibility for our employee under the FMLA. Please consider that your patient's need for care may include basic medical, hygienic, nutritional, safety or transportation needs, or the provision of physical or psychological care.

My Patient Needs:

Continuous Care:

Will your patient be incapacitated for a single, continuous period of time including time for treatment and recovery?

◯ No ◯ Yes

If yes, estimate the beginning and ending dates for the period of incapacity: from (date) through:

During this time, will the patient need care from another person? ◯ No ◯ Yes

If yes, explain (please print):

Intermittent Care:

Will your patient be incapacitated in a manner that requires intermittent or periodic care due to the medical condition, including time for treatment and recovery? ◯ No ◯ Yes

If yes, explain (please print):

Based upon your patient's medical history and your knowledge of the medical condition(s), estimate the frequency of the patient's need for intermittent care over the next 6 months (e.g. 1 time per week for 2 days per episode):

Frequency: time(s) per ◯ week or ◯ month

Duration: hour(s) or day(s) per episode

Anticipated duration of need (date) through:

Appointments:

Does your patient have medically necessary follow-up appointments that require assistance from another person?

◯ No ◯ Yes

If yes, explain frequency (please print):

Frequency: time(s) per ◯ week or ◯ month

From: (Date) through:

Health Care Provider Information (please print or attach business card)

Name: Specialty

Business Address: Phone: