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 to:

Campus HR Operations & Services
Gateway Building
Box 354963
4320 Brooklyn Ave NE
Seattle, WA 98195-4963
Fax: (206) 685-0636
Email: hrleaves@uw.edu

Do not submit to your unit or department

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:**

Manager's name:	If a child, the child's date of birth:

I am requesting

Continuous time off from work: ☐ Yes ☐ No If yes: from (date) _____ to (date) _____

A reduced work schedule: ☐ Yes ☐ No If yes: from (date) _____ to (date) _____
Describe reduced schedule (example: 4 hours per day, 5 days a week)

An intermittent leave: ☐ Yes ☐ No If yes: from (date) _____ to (date) _____
Describe intermittent need (example once a week for medical appointments)

FACULTY ONLY: I am requesting to use Faculty Paid Sick Leave if eligible: ☐ Yes ☐ No

Employee Signature: _____ Date: _____

PART 2 – Medical Facts: To Be Completed by Family Member's 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

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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:

PART 3 – Care Needs: To be Completed by Health Care Provider

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: _____

Family and Medical Leave Health Care Provider Certification for Family Member's Serious Health Condition	Employee Name:	EID:

Health Care Provider Signature:

_____ Date: _____