Campus HR - Parental Leave Employee Checklist

☐ Request time off work: Follow your department’s normal procedure for requesting leave, providing as much advance notice as possible. If at least 30 days advance notice is not possible, you must request leave as soon as you know you will need to be away from work.

☐ Make a Workday request for the entire time-period you are requesting to take off, including weekends. Use the “LOA – General Leave Request – Becoming a Parent” leave type for your request.

☐ You and the attending healthcare provider will need to complete and return the parental leave request form on page 2.

☐ If you want to participate in the Parental Shared Leave Program, please check the corresponding box in part 1 of the form and make a Workday request for the entire shared leave time-period you are requesting to take off, including weekends. Use the “LOA – Parental Shared Leave of Absence” leave type for your request. For more information regarding the Parental Shared Leave Program, see https://hr.uw.edu/ops/leaves/shared-leave-options/shared-leave/.

☐ You or the attending healthcare provider returns the request form to hrleaves@uw.edu or via fax to (206) 685-0636 within 15 days of your request for leave. Upon receipt, you will receive an e-mail from Campus HR confirming the arrival of the document.

☐ Your Campus HR Leave Specialist will review your request in conjunction with your rights under FMLA and the University’s Parental Leave Policy. This review will be followed by an e-mail designating your leave period.

☐ Work with your time and absence initiate to ensure unpaid time off, sick time off, vacation time off, parental shared leave, personal holiday, etc. is applied to each regularly scheduled workday during your approved leave period.

☐ Contact UW Benefits to discuss health care coverage and/or new dependent information at 206-543-8000 or ischelp@uw.edu.

☐ Contact us at hrleaves@uw.edu as soon as possible should any leave dates need to be changed or adjusted, or if you have any additional questions.
PART 1 - Employee Information: To Be Completed by Employee

<table>
<thead>
<tr>
<th>Employee name:</th>
<th>EID:</th>
<th>Employee phone:</th>
<th>Employee email:</th>
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</thead>
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<table>
<thead>
<tr>
<th>Department:</th>
<th>Supervisor’s name:</th>
<th>Supervisor’s email:</th>
</tr>
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</table>

I am requesting continuous time off work ☐ No ☐ Yes I am requesting a reduced work schedule as follows ☐ No ☐ Yes
From (date) / / to (date) / / hours/day for days/week until (date) / /

I am requesting an intermittent work schedule ☐ No ☐ Yes If yes, describe requested schedule (please print):

Employee Signature: ____________________________ Date: / /

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

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.

Our employee is requesting time off from work or a modified work schedule under the FMLA as the birth mother of a newborn child. Please provide the information requested below.

Expected date of delivery for your patient:

Expected dates of patient’s physical incapacity due to pregnancy and delivery (generally 6 weeks post-delivery {8 weeks for C-Section} unless other complications arise). Please DO NOT include period for baby bonding/parental leave, ONLY include time for recovery from childbirth.
From (date): / / to (date): / /

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

Name: ____________________________ Specialty: ____________________________
Business Address: ____________________________ Phone: ____________________________

Health Care Provider Signature: ____________________________ Date: / /