UNIVERSITY of WASHINGTON
HUMAN RESOURCES

(not for HMC or UWMC staff)

Family and Medical Leave Health Care Provider Certification for Personal 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:	Manager's name:	Manager's email:

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 Health Care Provider*

Our employee (your patient) is requesting leave from work and/or a modified work schedule under the Family and Medical Leave Act (FMLA). 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 our employee's request to take leave or modify their work schedule.

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 that require your patient to be off work and/or to work a reduced or intermittent work schedule (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:

PART 3 –Need for Leave or Work Schedule Adjustments: *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.

Family and Medical Leave Health Care Provider Certification for Personal Serious Health Condition	Employee Name:	EID:

My Patient Needs:

Continuous (Full) Leave:

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:

Intermittent Leave:

Will the condition(s) cause episodic flare-ups that prevent your patient from performing their job functions?

☐ 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 leave 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

This work schedule needs to be in place from (date): to (date):

Reduced Work Schedule:

If yes, describe the nature of the reduced schedule that you believe is medically necessary (e.g., 5 hours per day, 3 days per week), please print:

This work schedule needs to be in place from (date): to (date):

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:

Health Care Provider Signature:

_____ Date:_____

Reset Form

Revised 05/30/2025