UNIVERSITY of WASHINGTON
HUMAN RESOURCES

Faculty Parental Leave Checklist for the Birth Parent

- ☐ **Request a leave of absence** by following your department's normal procedure for requesting a 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** (or work with your department to ensure a request is made on your behalf) for the entire period you are requesting to take off, including weekends. Use the "LOA – General Leave Request – Becoming a Parent" leave type for your request.
- ☐ **Complete and submit** the attached Health Care Provider Certification form to hrleaves@uw.edu or via fax to (206) 685-0636. If you are requesting Faculty Paid Parental Leave, please check the box on the form. Once received, Your Leave & Accommodation Specialist will review your request in conjunction with your rights under FMLA and the Faculty Parental Leave Policy. You will receive an email designating your leave period.
- ☐ **Work with your Academic Partner** to ensure Paid Parental Leave Time Off 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 benefits@uw.edu
- ☐ **Contact hrleaves@uw.edu as soon as possible if your leave dates need to be changed or adjusted, or if you have any additional questions.**
- ☐ **Access additional information and resources:**
    - Pregnancy accommodation
    - UW childcare resources
    - Expectant parent planning guide

Revised: 4/1/2026
Contact: hrleaves@uw.edu

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Family and Medical Leave: Request for Faculty Parental Leave for Birth Parent

Instructions

Return the completed form to your leaves and accommodation specialist by emailing hrleaves@uw.edu or via fax: (206) 685-0636. UW Campus HR Operations & Services is located at 4320 Brooklyn Ave NE, Seattle, WA 98195-4963 | Campus Box 354963. Do not submit this form to your unit or department.

Section 1: Faculty information

1. Employee name: _____
2. Employee ID: _____
3. Department _____
4. Manager's name: _____
5. I am requesting continuous time off work:
    a. From: _____ To: _____
6. Expected date of delivery, adoption, or placement: _____
7. I am requesting Faculty Paid Parental Leave. ☐ Yes ☐ No

Faculty signature and date

Signature: _____ Date: _____

Section 2: Medical facts (to be completed by the health care provider)

GINA Notice

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 parent of a newborn child. Please provide the information requested below.

1. What is the expected date of delivery for your patient? _____

2. What are the expected dates of the patient's physical incapacity due to pregnancy and delivery (generally 6 weeks post-delivery [8 weeks for C-Section] unless other complications arise)? Please indicate medical needs only. Parental (bonding) leave is based on employee request.

   From (date): _____ To (date): _____

Heath care provider information

(Please print or attach business card.)

1. Name: _____
2. Specialty: _____
3. Business address: _____
4. Phone: _____

Health care provider signature

Signature: _____ Date: _____

Reset Form

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