University of Washington (not for HMC or UWMC staff)

Family and Medical Leave Certification of Health Care Provider for Personal Serious Health Condition

Human Resources

To Employee - Complete the following information on every page
Employee Name:
Department:
Employee Phone:
Employee Email:

To Employee: Complete Part 1 and arrange for your health care provider to complete Part 2. **Return the completed form as soon as possible, but no later than 15 calendar days after the date you receive it**. Return to the person or location indicated in the "Return to" space at the right. Contact this person or office if you believe that you will not be able to return the completed form within the specified time period.

Return to:
Campus HR Operations
Roosevelt Commons West
Box 354963
4300 Roosevelt Ave NE
Seattle, WA 98195-4963
Voice: (206) 543-2354 Fax: (206) 685-0636

PART 1 – To Be Completed by Employee (Please Print)

Supervisor's name	Supervisor's title	Supervisor's phone	Supervisor's email

I am requesting time off work ☐No ☐Yes

From (date) _____ to (date) _____

I am requesting a reduced work schedule as follows ☐No ☐Yes

_____ hours/day for _____ days/week until (date) _____

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

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 FMLA for a health condition. 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 adopt a modified work schedule. 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 "indeterminate" may not be specific enough for us to determine leave eligibility for our employee under the Family and Medical Leave Act. 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 the condition(s) that require our employee 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

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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:

Need for Leave or Work Schedule Adjustments

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) _____ to (date) _____

Will your patient be incapacitated in a manner that requires intermittent leaves of absence from work or a reduction in the amount of time worked per week due to his/her medical condition, including any time for treatment and recovery? ☐No ☐Yes

If yes, please describe the nature of the intermittent leave or reduced work schedule that you believe is medically necessary:

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

Will the condition(s) cause episodic flare-ups that prevent your patient from performing his/her job functions? ☐No ☐Yes

If so, please explain:

Based upon your patient's medical history and your knowledge of the medical condition, estimate the frequency of flare-ups and the duration of related incapacity that the patient may have over the next 6 months (e.g., 1 episode every 3 months lasting 1-2 days)

Frequency: _____ of times per _____ week(s) *-or-* _____ month(s)

Duration: _____ hours or _____ day(s) per episode

Are follow-up treatment appointments medically-necessary for your patient? ☐No ☐Yes

If yes, describe the anticipated treatment schedule and any treatment recovery period(s):

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

Name (please print) _____ Specialty _____

Business Address _____ Phone _____

Health Care Provider Signature

_____ Date _____