

University of Washington (not for HMC or UWMC staff) Family and Medical Leave Certification of Health Care Provider Maternity-related Disability and Parental leave Human Resources (not for medical centers staff)	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 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 UW Tower C-1 Box 359532 206-543-2354 (v) 206-685-0636 (fax)
--	---

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 from work for temporary pregnancy-related disability leave and for parental leave as follows: (date) _____ to (date) _____ If you are not requesting one, continuous period of time off work, describe your leave request in the space below.		I am requesting a reduced work schedule as follows <input type="checkbox"/> No <input type="checkbox"/> Yes If Yes: _____ hours/day for _____ days/week until (date) _____	
I am requesting an intermittent work schedule <input type="checkbox"/> No <input type="checkbox"/> Yes If yes, describe requested schedule: _____			
Employee Signature _____ Date _____			

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

Our employee is requesting time off from work or a modified work schedule under the FMLA for temporary, pregnancy-related disability leave and for parental leave. Please provide the information requested below. 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.

For Pregnancy-Related Incapacity

Expected date of delivery for your patient	Expected dates of your patient's physical incapacity due to pregnancy and delivery (not parental leave) From (date) _____ to (date) _____
Health Care Provider Information (please complete or attach business card)	
Name (please print) _____ Specialty _____	
Business Address _____ Phone _____	
Health Care Provider Signature _____ Date _____	