To Employee: Complete and return this form as soon as possible but no later than 15 calendar days after 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
UW Tower C-1
Box 359532
206-543-2354 (v) 206-685-0636 (fax)

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

<table>
<thead>
<tr>
<th>Supervisor’s name</th>
<th>Supervisor’s title</th>
<th>Supervisor’s phone</th>
<th>Supervisor’s email</th>
</tr>
</thead>
</table>

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/seek until (date) ____________

I am requesting an intermittent work schedule [ ] No [ ] Yes

If yes, describe requested schedule:

Employee Signature ________________________________ Date ________________

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### PART 2 – To Be Completed by Health Care Provider, Adoption Agency or Foster Care Agency

Our employee is requesting time off from work or a modified work schedule under the FMLA as the parent (other than the birth mother) of a newborn child, or of a newly placed, adopted, or foster child. 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 Birth Parent – Health Care Provider**

Expected date of baby’s delivery

Expected dates during which the birth mother is considered temporarily incapacitated due to pregnancy and delivery.

From (date) ____________ to (date) ____________

Birth Mother’s Health Care Provider information (please complete or attach business card)

Provider Name (please print) ________________________________

Business Address _____________________________________________ Phone __________________________

Provider Signature ________________________________ Date ________________

**For Adoptive or Foster Parents – Adoption or Foster Care Agency**

Anticipated date of adoption or of becoming a foster parent:

Provider information (please complete or attach business card)

Name of Agency or Organization (please print) ________________________________

Provider Name (please print) ________________________________

Business Address _____________________________________________ Phone __________________________

Provider Signature ________________________________ Date ________________