

University of Washington (not for HMC or UWMC staff) Family and Medical Leave Certification - Parental Leave for Parent Other than the Birth Mother Human Resources	To Employee - Complete the following information on every page
	Employee Name: _____
	Department: _____
	Employee Phone: _____
	Employee Email: _____

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)

Supervisor's name _____	Supervisor's title _____	Supervisor's phone _____	Supervisor's email _____
I am requesting time off work <input type="checkbox"/> No <input type="checkbox"/> Yes From (date) _____ to (date) _____		I am requesting a reduced work schedule as follows <input type="checkbox"/> No <input type="checkbox"/> 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 – 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 _____