

UNIVERSITY OF WASHINGTON
HEALTH CARE PROVIDER STATEMENT

Shared Leave Eligibility Verification

PART 1 - EMPLOYEE COMPLETES THIS SECTION

UW Employee Name (Last)		(First)	(M.I)	Department
Employee's Job Title			Work Email	Work Phone
Work Schedule (days/hours)				
If you are requesting shared leave to care for a family or household member, provide:				
Family/Household Member's Name		Family/Household Member's Relationship		
Name of Treating Health Care Provider		Patient No./Date of Birth	Health Care Provider's Phone	

I hereby authorize the above-named health care provider to complete this form and disclose to the University of Washington and its authorized representatives the diagnosis, treatment and anticipated duration of relevant conditions

I understand that it may be necessary for the University representatives to share this information for purposes of leave administration and approval of my request to receive shared leave. I authorize the University to share this information among appropriate staff and authorized representatives to the extent necessary for that purpose. I understand that the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). My health record may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse.

Once disclosed, the law does not always require the recipient of my information to maintain the confidentiality of my health care information. I understand that I have the following rights: a) to inspect or receive a copy of my protected health information, b) to receive a copy of this signed authorization, and c) to refuse to sign this authorization. I understand that information obtained under this release is a confidential medical record and is maintained appropriately. This authorization is valid for 90 days after the date of my signature below. However, I understand that I may revoke this consent, in writing, at any time except to the extent that action has already been taken based on the original authorization. I also understand that the above-named health care provider will not condition treatment or payment based on receipt of this signed authorization.

By signing this page, I acknowledge that I have read and agree to the terms described above.

Check one: I am the employee requesting shared leave, OR
 I am the family/household member of the UW employee requesting shared leave

Signature _____ Date _____

To Employee: DO NOT RETURN THIS FORM TO YOUR SUPERVISOR
Return the completed form to the UW Human Resources Operations office that has been designated below
(Human Resources Operations – Enter the address of the office to which the form should be returned)

HR Operations Offices	
Harborview Medical Center Medical Centers Human Resources 325 Ninth Avenue Seattle, WA 98104-2499 UW Box 359715 Voice: (206) 744-9220 Fax: (206) 744-9955	Health Sciences Operations D302 Health Sciences UW Box 357250 Voice: (206) 543-9406 Fax: (206) 685-2845
Upper Campus Operations Bloedel Hall, Lower Level Box 354561 Voice: (206) 543-2354 Fax: (206) 685-0636	UW Medical Center Operations BB150 UWMC Box 356054 Voice: (206) 598-6116 Fax: (206) 598-4610

PART 2 - HEALTH CARE PROVIDER COMPLETES THIS SECTION

Your patient is asking you to disclose information about his/her health condition so that the University of Washington can process a request to allow a University employee to receive leave donations from other employees.

To be eligible to receive such donations our employee must have a severe, extraordinary, or life-threatening illness or injury or have to care for a family or household member with such a condition. The information you provide is critical to our ability to process our employee's request to receive leave donations from other employees.

Please complete this form and return it as directed at the bottom or Part 1 of this form. If you fax the completed form, please send the original hard copy by mail to the address designated at the bottom of page one.

EVALUATION SUMMARY

Patient Name: _____

Pertinent Diagnosis(es)	Anticipated duration of this condition	I consider this condition to be a severe, extraordinary, or a life-threatening illness or injury	
		YES	NO

Check any of the following that apply. My patient is:

- Being hospitalized
- Having surgery
- Assigned to bed rest
- Undergoing treatment in a medical facility (chemotherapy, dialysis, etc)

Anticipated dates of treatment Dates: (mm/dd/yy) _____ to (mm/dd/yy) _____

Is this condition the result of an on-the-job illness or injury? Yes No

HEALTH CARE PROVIDER INFORMATION

Health Care Provider Name (please print or type)		Provider's Specialty: Please indicate any board certifications	
Health Care Provider's Address (Street)	City	State	ZIP
Health Care Provider Signature _____		Phone No.	Fax No.
Date _____		- -	- -