

Family and Medical Leave Certification of Health Care Provider

Human Resources

Within 15 calendar days of the date you receive this form, please return completed Parts 1 and 2 to The Human Resources Consultant specified at right. If no Human Resources Consultant is specified, return the form to the HR Operations Office serving the department where you work (see the bottom of page 3)

Rachel Vane, HR Specialist
 UW Facilities Services – Box 352215
 Seattle, WA 98195-2215
 PHONE: (206) 221-2397
 FAX: (206) 221-7552

Employee Information:

If you meet the eligibility requirements under the federal Family and Medical Leave Act (FMLA):

- You have a right to receive up to 12 weeks of leave each calendar year.
- If you receive employer paid benefits coverage, you will be able to continue your basic insurance coverage during FMLA Leave.
- As provided under the law, and provided you comply with University policy, you will be returned to the same or an equivalent job with the same pay, benefits, and terms and conditions of employment on your return from FMLA Leave, unless there is a reduction in force or reorganization that affects your position. In such an event you would have the same rights as other employees affected by a reduction in force or reorganization.
- If your leave request is due to maternity and/or parental leave, you may be entitled to additional leave rights under state law. Please contact your Human Resources Operations Office for additional information or visit the UW Human Resources web site at: <http://www.washington.edu/admin/hr/polproc/leave/fmla/>

PART 1 – To Be Completed by Employee

Employee's Name (please print):	Department	Phone	Email
Supervisor's Name (please print):	Supervisor's Title	Supervisor's Phone	Supervisor's Email

Family and Medical Leave is needed for (check one):

Personal health condition

Family member's health condition – Relationship Parent Spouse Child Other - specify _____
 (If for family member, fill out PART 1A)

Newborn or newly placed adoptive/foster child)

Regular Work hours per week <input type="checkbox"/> 40 <input type="checkbox"/> 36 <input type="checkbox"/> 32 <input type="checkbox"/> 20 <input type="checkbox"/> Other____	Days per Week Scheduled to Work <input type="checkbox"/> M - F <input type="checkbox"/> Other_____	Work Shift <input type="checkbox"/> Days <input type="checkbox"/> Evening <input type="checkbox"/> Night <input type="checkbox"/> Other_____
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I am requesting leave: From (Date)_____ to (Date)_____	I am requesting a reduced work schedule: From _____hours/week to _____hours/week until (Date)_____
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I am requesting an intermittent work schedule (describe requested schedule)

If you are requesting a reduced or intermittent work schedule because of your own serious health condition, please provide your health care provider with a description of your job tasks. If you need assistance contact your unit's Human Resources Consultant.

PART IA - Leave to Care for a Family Member

Please describe the care you will provide

Employee Signature _____ Date _____

Part 2 – To be Completed by Health Care Provider

The employee presenting you with this form is requesting leave from work for reasons described in PART 1 of this form. Please provide the information requested below to certify the necessity of the requested leave. Please only provide information relating to the condition for which the employee is requesting leave.

Patient Health Condition	If Yes date condition commenced:
Is patient's condition a "Serious Health Condition" as defined on page 3 <input type="checkbox"/> Yes <input type="checkbox"/> No?	

If patient's condition meets one more of the serious health condition definitions please check the applicable category(ies)

Hospital/Inpatient Care Absence plus treatment Pregnancy A Chronic Condition

Permanent or Long Term Incapacity Multiple Treatments

Is the patient incapacitated from working? Yes No If yes, estimated duration of incapacity_____

If the condition is a chronic condition, or pregnancy, please describe the likely duration and frequency of the episodes of incapacity.

Please describe the medical facts supporting your certification that would help us to understand how the patient's condition meets one of the "Serious Health Condition" categories you checked.

Treatment Plan – If the employee will be absent from work on an intermittent or part-time basis, please provide the following information or you may attach a copy of the patient's treatment plan

Probable number of treatments_____ Interval between treatment_____

Dates of treatment if known_____ Period required for recovery if any_____

If any treatments will be provided by another provider of health services (e.g. physical therapist) please describe the nature of the treatment

If a regimen of continuing treatment under your supervision is required, please provide a general description of the regimen (e.g. prescription drugs, etc)

For Patients Who Are UW Employees with attached job description: Is the patient able to perform all of the essential job functions specified in the job description? Yes No. If NO, Which functions cannot be performed?

Employee Work Schedule - The employee's regular work schedule is described in PART 1 of this form. If the employee must be absent from work, please provide the following information

Is it necessary for the employee to work a reduced or intermittent work schedule because of the employee's or family member's health condition Yes NO

If Yes what is the work schedule or work hours you are recommending_____

What is the duration of time that the recommended schedule should be in place._____

If leave is required to care for an employee's family member, please respond to the following:

Yes NO Does your patient require assistance for basic medical or personal needs, safety, or transportation

Yes NO Would the employees presence to provide psychological comfort be beneficial to the patient or to assist in the patients recovery.

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

Name (please print)_____ Phone_____ Specialty_____

Business Address_____

Health Care Provider Signature_____ date_____

