UNIVERSITY of WASHINGTON
OFFICE OF ACADEMIC PERSONNEL
Academic Human Resources

Leave Certification for Family Member's Serious Health Condition (For Academic Personnel Use Only)

To employee - complete the following information on every page:	
Employee name:	
Employee EID:	
Department:	
Employee phone:	Employee email:

To Employee: Complete Part 1 and arrange for your family member's health care provider to complete Part 2. **Return all sections of the completed form as soon as possible but no later than 15 days from the start of your leave. Completed forms should be submitted directly to Academic HR and not to your college, school, or department.** Contact Academic Human Resources if you believe that you will not be able to return the completed form within the specified time period.

PART 1 – To be completed by employee (please print)

Family member's name	Family member's relationship to you ☐ Parent ☐ Child ☐ Spouse ☐ Domestic Partner ☐ Brother/Sister ☐ Grandchild ☐ Grandparent If a child, the child's date of birth:

Describe type of care you will provide to your family member

I am requesting to use paid sick leave if I am eligible ☐ No ☐ Yes

I am requesting time off work ☐ No ☐ Yes If Yes: From (date) _____ to (date) _____	I am requesting a reduced work schedule as follows ☐ No ☐ Yes If Yes: _____ hours/day for _____ days/week until (date) _____

I am requesting an intermittent work schedule ☐ No ☐ Yes If yes, describe requested schedule:

Employee Signature:_____ Date:_____

PART 2 – Medical Facts: to be completed by family member's Health Care Provider

Our employee is requesting leave from work or a modified work schedule to care for a family member who is your patient. Please provide the information requested below so that we can process our employee's leave request. Only provide information regarding the condition(s) that relate to your patient's need for care from another person. 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) _____

For health condition-related time off work (other than pregnancy)

Several of the following questions ask about the frequency or duration of a condition or treatment. We know that health conditions can vary or change over time, so please provide your best estimate in response to these questions, being as specific as you can. Using terms such as "lifetime," "unknown," or "indeterminate" may not be specific enough for us to determine leave eligibility for our employee.

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Describe the medical facts related to your patient's condition(s) (medical facts may include symptoms, diagnosis, or any plan for continuing treatment or therapy)

Approximate date condition began	Probable duration of condition

Was your patient admitted for an overnight stay in a hospital, hospice, or residential medical care facility? ☐ No ☐ Yes

If yes, dates of admission:

Will your patient need treatment visits at least twice per year due to the condition? ☐ No ☐ Yes

Was medication, other than over-the-counter medication, prescribed? ☐ No ☐ Yes

Was your patient referred to other health care provider(s) for evaluation or treatment? ☐ No ☐ Yes
If yes, describe the nature and expected duration of the treatments:

For health condition-related time off work: requirements for care

In answering the following questions, please consider that your patient's need for care may include assistance with basic medical, hygienic, nutritional, safety or transportation needs, or the provision of physical or psychological care.

Will your patient be incapacitated for a single, continuous period of time, including time for treatment and recovery? ☐ No ☐ Yes

If yes, estimate the beginning and ending dates for the period of incapacity: from (date) _____ to (date) _____

During this time, will the patient need care from another person? ☐ No ☐ Yes If yes, explain the care needed by the patient:

Will your patient be incapacitated in a manner that requires intermittent or periodic care due to his/her medical condition, including any time for treatment and recovery? ☐ No ☐ Yes

If yes, please describe the nature of the intermittent or periodic incapacity, and the care that your patient will require:

This need for care will exist from (date) _____ to (date) _____

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Will the condition(s) cause episodic flare-ups that prevent your patient from participating in normal daily activities? ☐No ☐Yes
If yes, please explain:

Based upon your patient's medical history and your knowledge of the medical condition, estimate the frequency of flare-ups and the duration of related incapacity that the patient may have over the next 6 months (e.g., 1 episode every 3 months lasting 1-2 days)

Frequency: _____ of times per _____ week(s) *-or-* _____ month(s)

Duration: _____ hours or _____ day(s) per episode

Is medical care necessary during these flare-ups? ☐No ☐Yes
If yes, explain the care your patient will need:

Are follow-up treatment appointments medically necessary for your patient? ☐No ☐Yes
If yes, describe the anticipated treatment schedule and any treatment recovery period including any care your patient will need:

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

Name (please print) _____ Specialty _____

Business Address _____ Phone _____

Health Care Provider Signature _____ Date _____

Return to:	AHR USE ONLY
Academic Human Resources Box 351270 Seattle, WA 98195-1270 Fax (206) 221.4622 Email: apleaves@uw.edu	FMLA Eligible: ____No ____Yes Total Days Requested_____ Reviewed by (initials) _____ Date:_____