UNIVERSITY of WASHINGTON
OFFICE OF ACADEMIC PERSONNEL
Academic Human Resources

Leave Certification for
Maternity-Related Disability and Parental leave
(For Academic Personnel Use Only)

To employee - complete the following information:	
Employee Name:	
Employee EID:	
Department:	
Employee phone:	Employee email:

To employee: Complete Part 1 and arrange for your health care provider to complete Part 2. **Return 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. **For childbirth and post-partum recovery, you may complete the forms after the baby is born to ensure dates of leave are correct.**

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

I am requesting time off work from work for temporary pregnancy-related disability leave and for parental leave as follows:

(date) _____ to (date) _____

If you are not requesting one, continuous period of time off work, describe your leave request in the space below.

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:

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

Employee Signature _____ Date _____

AHR USE ONLY: FMLA Eligible ☐No ☐Yes

PART 2 – Medical Facts: to be completed by the Health Care Provider

Our employee is requesting time off from work or a modified work schedule for temporary, pregnancy-related disability leave and for parental leave. 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 Pregnancy-Related Incapacity

Expected date of delivery for your patient

Expected dates of your patient's inability to work due to pregnancy, delivery, and postpartum recovery:

From (date) _____ to (date) _____

Health Care Provider Information

Name (please print) _____ Specialty _____

Business Address _____ Phone _____

Health Care Provider Signature _____ Date _____

Return to:
Academic Human Resources
Box 351270
Seattle, WA 98195-1270
Email: apleaves@uw.edu
Fax (206) 221.4622

AHR USE ONLY
FMLA Eligible: ____No ____Yes

Total Days Requested_____

Reviewed by (initials) _____ Date:_____