Family Care Leave
Certification of Health Care Provider

Please return the completed certification form to your Human Resources Office within 15 calendar days.

PART I is completed by the employee requesting leave.

PART II is completed by a health care provider.

PART 1 – To Be Completed by Employee

<table>
<thead>
<tr>
<th>Employee’s Name (please print):</th>
<th>Department</th>
</tr>
</thead>
<tbody>
<tr>
<td>Employee’s Signature</td>
<td>Date</td>
</tr>
</tbody>
</table>

Family Care Leave is needed to care for (check one)

☐ Parent  ☐ Spouse  ☐ Child  ☐ Grandparent  ☐ Parent-in-law

Employee’s normal work schedule:
Hours per week _____
Days of week and shift you are scheduled to work __________________________
Time off requested/needed (dates) ________________________________________

PART I A - To Be Completed by the Employee Needing Leave to Care for a Family Member

State the care you will provide and an estimate of the period during which care will be provided.

Employee Signature ___________________________________________ Date _____________

Definition of Serious Health Condition (adult) and Treatment or Supervision (child)

For an adult a Serious Health Condition is defined as:

1. An illness, injury, impairment, or physical or mental condition that involves any period of incapacity or treatment connected with inpatient care (i.e., an overnight stay) in a hospital, hospice, or residential medical care facility, and any period of incapacity or subsequent treatment or recovery in connection with such inpatient care;

2. Continuing treatment by or under the supervision of a health care provider or a provider of health care services and which includes any period of incapacity (i.e., inability to work, attend school or perform other regular daily activities).

For a child Treatment or Supervision is defined as:

1. Any medical condition requiring treatment or medication that the child cannot self administer;

2. Any medical or mental health condition which would endanger the child's safety or recovery without the presence of a parent or guardian; or

3. Any condition warranting treatment or preventive health care such as physical, dental, optical or immunization services, when a parent must be present to authorize and when sick leave may otherwise be used for the employee's preventive health care.
**Part 2 – To be Completed by Health Care Provider**

Employee (Name) ________________________________ is requesting leave from work for reasons cited 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 - Adult**
Is the patient’s condition a “serious health condition” as defined on page 2 of this form?
- [ ] Yes
- [ ] No

**Patient Health Condition - Child**
Does the child have a health condition that requires “treatment or supervision” as defined on page 2 of this form?
- [ ] Yes
- [ ] No

Please describe the medical facts that support your certification:

<table>
<thead>
<tr>
<th>Date the patient’s condition commenced:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Probable duration of the patient’s condition:</td>
</tr>
<tr>
<td>Is the patient incapacitated? [ ] Yes [ ] No</td>
</tr>
<tr>
<td>If yes, what is the probable duration of the present incapacity?</td>
</tr>
</tbody>
</table>

**Health Care Provider Information**

| Health Care Provider Name (Please Print): __________________________ | Phone __________________ |
|---------------------------------------------------------------|
| Health Care Provider’s Medical Specialty: ________________________ |
| Health Care Provider’s Signature: ___________________________ | Date ________________ |
| Health Care Provider’s Address: ______________________________ |

**Please Return This Form To:**

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FS HR Specialist
Box 352215
Seattle, WA 98195-2215
Voice: (206) 221-4349  Fax: (206) 543-5135
Email: maxmarsh@uw.edu