UNIVERSITY of WASHINGTON
HUMAN RESOURCES

Shared Leave
Health Care Provider Certification for UW Facilities Employees Only

PART 1 – Employee Information: To Be Completed by Employee

UW Employee Name (Last, First, MI):		UW EID:	Department:
Employee's Job Title:	Dept HR Contact:	Preferred Email	Work Phone:
Is this condition the result of an on-the-job injury? ☐ Yes ☐ No		Home or Cell Phone:	
Are you requesting shared leave to care for a family or household member? Yes No			
If yes, please provide Family/Household Member's Name:			
Name of Treating Health Care Provider:			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 household member of the UW employee requesting shared leave, OR
☐ I am the family member of the UW employee requesting shared leave
For family member, enter relationship to UW employee_____

Patient Signature: _____ Date:

The State of Washington's Shared Leave Program is intended to allow employees to assist each other with leave donations to help cope with severe, extreme and/or life threatening health crises as well as temporary disability for pregnancy and parental leave. Donated leave is intended to help employees in these circumstances to bridge unexpected absences that they do not have paid leave to cover and which would cause them to go into unpaid status for a period of time.

Examples of "extraordinary or severe" situations that are typically approved include:
Major surgery with inpatient hospital stay; outpatient surgery for severe condition; cancer and treatment; hospitalization for a severe physical or mental condition; enrollment in an ongoing behavioral health treatment program (inpatient or day) requiring continuous leave from work; bed rest due to high risk pregnancy-related complications.

Definition of temporary pregnancy disability: pregnancy-related medical condition or miscarriage

Conditions that are typically not approved include:
Flu; chicken pox; sprained ankle; elective cosmetic surgery; intermittent leave for chronic, ongoing medical conditions.

For more information about shared leave visit http://hr.uw.edu/ops/leaves/shared-leave/

Shared Leave – Health Care Provider Certification	Employee Name:	Department:

PART 2 – Health Care Provider: To Be Completed by Health Care Provider

Your patient is asking you to disclose information about themselves so that the University of Washington can process a request to receive leave donations from other employees. The qualification criteria to receive shared leave are explained on page 1 of this form. The information you provide will be used to determine whether the medical condition meets the criteria for receiving shared leave.

Please complete this form and return both pages as directed at the bottom of this page.

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 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.

EVALUATION SUMMARY

Patient Name (Last, First, MI):			Relationship to employee:
Pertinent Diagnosis(es) (name and description of condition)	Date condition commenced or diagnosed	Anticipated End Date	Please describe how this diagnosis meets the definition of a severe, extreme or life threatening illness or injury or pregnancy disability

Provide additional information regarding your diagnosis by checking all of the following that apply:	Start Date	End Date
☐ Major surgery with inpatient hospital stay		
☐ Outpatient surgery for a severe condition		
☐ Hospitalization for severe physical or mental condition		
☐ Enrollment in an ongoing behavioral health treatment program (inpatient or day) requiring continuous leave from work		
☐ Bed rest due to high risk pregnancy-related complications (mother and/or fetal endangerment)		
☐ Treatment for condition described above (e.g., chemotherapy, dialysis, radiation etc.)		
☐ For UW Employees: Patient will need to be on leave from work		

Notes:

HEALTH CARE PROVIDER INFORMATION

Health Care Provider Name (please print or type): Provider's	Specialty:
Health Care Provider's Address:	
Health Care Provider Signature: _____ Date:	Email: Phone:

Return the completed form to the UWF Partner Resources office.
(To Employee: DO NOT RETURN THIS FORM TO YOUR SUPERVISOR)

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