UNIVERSITY of WASHINGTON
HUMAN RESOURCES

For Use by UW Facilities Employees Only

Family and Medical Leave
Certification of Health Care Provider for Family Member's Serious Health Condition (FMLA – HCP)

Return the completed form as soon as possible, but no later than 15 calendar days after the date you receive it to:

UW Facilities
Partner Resources
fsleave@uw.edu
Fax: (206) 543-5135

PART 1- Employee Information: To Be Completed by Employee

Employee name:	EID:	Employee phone:	Employee email:
Employee department:	Family Member's relationship to you: If a child, the child's date of birth: / /		

Describe the care you will provide an estimate the amount and/or frequency of leave needed:
(Please be as specific as possible regarding your need for leave. Examples: "up to 3 mornings or afternoons per month to take my mother to health care appointments" or "1 week to care for my son following surgery")

Employee Signature: Date: / /

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

Our employee is requesting leave from work and/or a modified work schedule under the FMLA 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.

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

Approximate date condition(s) began: / /	Probable duration of condition(s) (days, weeks, months):

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 to have 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:

PART 3 – Requirements for Care: To Be Completed by Health Care Provider

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 "as needed" may not be specific enough for us to determine leave eligibility for our employee under the Family and Medical Leave Act. Please consider that your patient's need for care may include basic medical, hygienic, nutritional, safety or transportation needs, or the provision of physical or psychological care.

My Patient Needs:

Continuous 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, please explain:

Intermittent Care:

Will your patient be incapacitated in a manner that requires intermittent or periodic care due to their medical condition, including time for treatment and recovery ? ☐ No ☐ Yes
If yes, please explain:

Based upon your patient's medical history and your knowledge of the medical condition(s), estimate the frequency of the patient's need for intermittent care over the next 6 months (e.g. 1 time per week for 2 days per episode)

Frequency: time(s) per week or month

Duration: hour(s) or day(s) per episode

Anticipated duration of need (date) / / to (date) / /

Appointments:

Are follow-up treatment appointments medically necessary for your patient and will they need assistance from another person to get there? ☐ No ☐ Yes
If yes, please explain frequency:

Frequency: time(s) per week or month

From: (Date) / / to: (Date) / /

The Genetic Information Nondiscrimination Act of 2008 (GINA):
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.

Health Care Provider Information

Name: (please print) Specialty:

Business Address: Phone:

Health Care Provider Signature:

_____ Date: / /

EMPLOYEE RIGHTS
UNDER THE FAMILY AND MEDICAL LEAVE ACT

THE UNITED STATES DEPARTMENT OF LABOR WAGE AND HOUR DIVISION

LEAVE ENTITLEMENTS

Eligible employees who work for a covered employer can take up to 12 weeks of unpaid, job-protected leave in a 12-month period for the following reasons:

- The birth of a child or placement of a child for adoption or foster care;
- To bond with a child (leave must be taken within 1 year of the child's birth or placement);
- To care for the employee's spouse, child, or parent who has a qualifying serious health condition;
- For the employee's own qualifying serious health condition that makes the employee unable to perform the employee's job;
- For qualifying exigencies related to the foreign deployment of a military member who is the employee's spouse, child, or parent.

An eligible employee who is a covered servicemember's spouse, child, parent, or next of kin may also take up to 26 weeks of FMLA leave in a single 12-month period to care for the servicemember with a serious injury or illness.

An employee does not need to use leave in one block. When it is medically necessary or otherwise permitted, employees may take leave intermittently or on a reduced schedule.

Employees may choose, or an employer may require, use of accrued paid leave while taking FMLA leave. If an employee substitutes accrued paid leave for FMLA leave, the employee must comply with the employer's normal paid leave policies.

BENEFITS & PROTECTIONS

While employees are on FMLA leave, employers must continue health insurance coverage as if the employees were not on leave.

Upon return from FMLA leave, most employees must be restored to the same job or one nearly identical to it with equivalent pay, benefits, and other employment terms and conditions.

An employer may not interfere with an individual's FMLA rights or retaliate against someone for using or trying to use FMLA leave, opposing any practice made unlawful by the FMLA, or being involved in any proceeding under or related to the FMLA.

ELIGIBILITY REQUIREMENTS

An employee who works for a covered employer must meet three criteria in order to be eligible for FMLA leave. The employee must:

- Have worked for the employer for at least 12 months;
- Have at least 1,250 hours of service in the 12 months before taking leave;* and
- Work at a location where the employer has at least 50 employees within 75 miles of the employee's worksite.

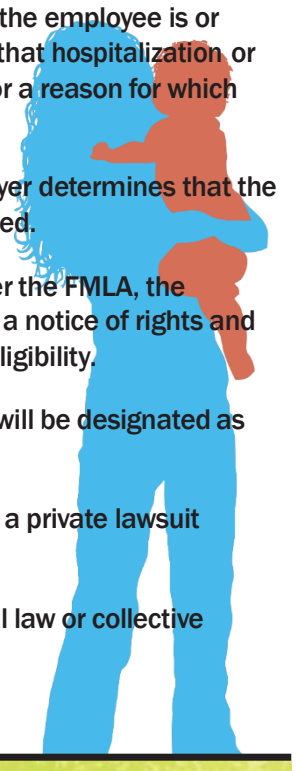
*Special "hours of service" requirements apply to airline flight crew employees.

REQUESTING LEAVE

Generally, employees must give 30-days' advance notice of the need for FMLA leave. If it is not possible to give 30-days' notice, an employee must notify the employer as soon as possible and, generally, follow the employer's usual procedures.

Employees do not have to share a medical diagnosis, but must provide enough information to the employer so it can determine if the leave qualifies for FMLA protection. Sufficient information could include informing an employer that the employee is or will be unable to perform his or her job functions, that a family member cannot perform daily activities, or that hospitalization or continuing medical treatment is necessary. Employees must inform the employer if the need for leave is for a reason for which FMLA leave was previously taken or certified.

Employers can require a certification or periodic recertification supporting the need for leave. If the employer determines that the certification is incomplete, it must provide a written notice indicating what additional information is required.



EMPLOYER RESPONSIBILITIES

Once an employer becomes aware that an employee's need for leave is for a reason that may qualify under the FMLA, the employer must notify the employee if he or she is eligible for FMLA leave and, if eligible, must also provide a notice of rights and responsibilities under the FMLA. If the employee is not eligible, the employer must provide a reason for ineligibility.

Employers must notify its employees if leave will be designated as FMLA leave, and if so, how much leave will be designated as FMLA leave.

ENFORCEMENT

Employees may file a complaint with the U.S. Department of Labor, Wage and Hour Division, or may bring a private lawsuit against an employer.

The FMLA does not affect any federal or state law prohibiting discrimination or supersede any state or local law or collective bargaining agreement that provides greater family or medical leave rights.

For additional information or to file a complaint:

1-866-4-USWAGE

(1-866-487-9243) TTY: 1-877-889-5627

www.dol.gov/whd

U.S. Department of Labor | Wage and Hour Division

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