Washington
Paid Family & Medical Leave
Employment Security Department

Paid Leave Certification Forms

Which form do I need?

Medical leave due to your own serious health condition

Certification of Serious Health Condition Form (pages 1 and 2) or the US Department of Labor's FMLA Certification of Health Care Provider for Employee's Serious Health Condition Form to verify your own serious health condition, including medical leave related to pregnancy and giving birth.

Family leave to take care of a family member with a serious health condition

Certification of Serious Health Condition Form (pages 1 and 2) or the US Department of Labor's FMLA Certification of Health Care Provider for Family Member's Serious Health Condition Form to verify your family member's serious health condition.

Parents taking family (bonding) leave following the birth of a child

Certification of Birth Form (last page), or a copy of your child's birth certificate, or a copy of documentation from the hospital showing your child's date of birth.

Other types of leave

Do not use this form for military exigency leave or for bonding leave when a child is placed in your home for adoption, foster care, or other approved placement types. Visit PaidLeave.wa.gov for information and required forms for these types of leave.

How do I submit my forms?

Upload completed forms through your Paid Leave account or include them with your application. You do not need to set up your Paid Leave account before your healthcare provider completes your forms.

Do not submit any certification forms via email. Emailed documents will not be accepted. Instructions for how to upload documents are on our website at paidleave.wa.gov/technical-support.

Can someone else complete my forms for me?

You may authorize another individual to act on your behalf for the purposes of Paid Family and Medical Leave benefits by having them complete a Designated Authorized Representative form. Contact us at 833-717-2273 to request a copy of the Designated Authorized Representative form.

Your authorized representative can sign page 1 of the Certification for Serious Health Condition on your behalf. Your authorized representative cannot sign for a healthcare provider when completing any documentation requiring a healthcare provider's signature.

Questions?

If you have any questions, please contact us at 833-717-2273 or paidleave@esd.wa.gov.

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What kinds of healthcare providers can sign these forms?

Healthcare providers who are authorized to sign this form are defined in RCW 50A.05.010 and WAC 192-500-090. Generally, "healthcare provider" means:

- A physician or an osteopathic physician who is licensed to practice medicine or surgery, as appropriate, by the state in which the physician practices;
- Nurse practitioners, nurse-midwives, midwives, clinical social workers, physician assistants, podiatrists, dentists, clinical psychologists, optometrists and physical therapists licensed to practice under state law and who are performing within the scope of their practice as defined under state law by the state in which they practice;
- A healthcare provider listed above who practices in a country other than the United States, who is authorized to practice in accordance with the law of that country, and who is performing within the scope of the healthcare provider's practice as defined under such law; or
- Other providers permitted to certify the existence of a serious health condition under the federal FMLA.

Certification of Serious Health Condition Form – Pages 1 & 2

Who should use this form?

The information on the Certification of Serious Health Condition Form is required when applying for:

- Medical leave due to your own serious health condition.
- Medical leave due to your own pregnancy/child's birth.
- Family leave to take care of a family member with a serious health condition.

We cannot approve your application for these types of medical leave or family leave without certification from a healthcare provider.

You may submit a complete the US Department of Labor's FMLA form for an employee's serious health condition or family member's serious health condition form instead of this form. However, we may require additional documentation if there is a question about the certification provided.

How do I complete this form?

Complete section one of this form, then have your or your family member's healthcare provider complete section two. The healthcare provider must be able to certify your or your family member's serious health condition. The definition of a serious health condition is provided on the next page.

Upload both pages of the completed Certification of Serious Health Condition form through your Paid Leave account or include it with your application.

What happens if the serious health condition changes and I need more leave?

If the serious health condition changes after you submit this form, contact us at 833-717-2273 to let us know. A new Certification of Serious Health Condition will be required to extend the duration of leave. Please do not email a new medical certification.

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Instructions for healthcare providers

Certification of Serious Health Condition Form (pages 1 and 2) is used to certify a serious health condition in order to qualify for Paid Family and Medical Leave. Your patient may be applying due to their own serious health condition or to care of a family member with a serious health condition. Qualifying serious health conditions are described below. Answer each question to the best of your medical knowledge, based on your examination of the patient.

Certification of Birth Form (last page) is used to document a child's birthdate for parents taking family (bonding) leave following the birth of a child.

What is a serious health condition?

A "serious health condition" is defined in RCW 50A.05.010 and healthcare providers should review the complete definition before certifying a patient's condition. Generally, a serious health condition could include an illness, injury, impairment, or physical or mental condition that:

Involves inpatient care: Inpatient care in a hospital, hospice, or residential medical care facility, including any period of incapacity; or
Requires continuing treatment by a healthcare provider: A serious health condition involving continuing treatment by a healthcare provider includes any one or more of the following:

- Incapacity; A period of incapacity of more than three consecutive days and subsequent treatment or period of incapacity relating to the same condition. Incapacity means an inability to work, attend school, or perform other regular daily activities because of a serious health condition, treatment of that condition or recovery from it, or subsequent treatment in connection with such inpatient care.
- Pregnancy: Any period of incapacity due to pregnancy, or for a serious health condition involving prenatal care;
- Chronic conditions: Any period of incapacity or treatment for such incapacity due to a chronic serious health condition. A chronic serious health condition is one which:
  - Continues over an extended period of time, including recurring episodes of a single underlying condition;
  - Requires periodic visits to a healthcare provider; and
  - May cause episodic rather than a continuing period of incapacity, including asthma, diabetes and epilepsy.
- Permanent/Long-term: A period of incapacity which is permanent or long-term due to a condition for which treatment may not be effective. The employee or family member must be under the continuing supervision of, but need not be receiving active treatment by, a healthcare provider, including Alzheimer's, a severe stroke, or the terminal stages of a disease; or
- Multiple treatments: Any period of absence to receive multiple treatments, including any period of recovery from the treatments.
- Substance abuse may be a serious health condition if the treatment meets other requirements in this definition.

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Certification of Serious Health Condition Form

Certification of Serious Health Condition

Instructions: Complete section one of this form, then have your or your family member's healthcare provider complete section two. Please include your name on each page. **Upload both pages to your Paid Leave account or include them with your application.**

Section one: Your information

To be completed by the person applying for leave before having the healthcare provider complete section two

Paid Leave Customer ID number *(if known)***:**

Name:

Date of birth: ____ / ____ / ____

Reason for taking Paid Family and Medical Leave

☐ **For my own serious health condition**

Instructions: Have your healthcare provider complete page 2 of this medical certification, listing yourself as the patient.

☐ **For medical reasons related to my own pregnancy**

Instructions: Have your healthcare provider complete page 2 of this medical certification, listing yourself as the patient. If applying for family (bonding) leave following the birth of a child, you and your healthcare provider should also fill out the Certification of Birth form.

☐ **To care for a family member during their serious health condition**

The family member needing care is my:

- ☐ Child, son-in-law, daughter-in-law
- ☐ Spouse or registered domestic partner
- ☐ Parent or spouse's parent
- ☐ Sibling
- ☐ Grandparent or spouse's grandparent
- ☐ Grandchild

Instructions: Have your family member's healthcare provider complete page 2 of this medical certification, listing your family member as the patient.

Authorization and Signatures

I authorize Paid Family and Medical Leave to use the information on this form to determine my eligibility for paid family or medical leave benefits and I attest that I am applying for Paid Leave due to my own serious health condition or to take care of a family member with a serious health condition.

Signature *(required)***:**	**Date:**

If the person applying for benefits is unable to sign this form because of a serious health condition or injury, an authorized representative may sign on their behalf, provided they also submit a Designated Authorized Representative form.

Authorized representative name:

Signature:	**Date:**

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Certification of Serious Health Condition Form

Name of person applying for leave: _____

Instructions: *Answer all questions fully and completely. Limit your responses to the condition for which the person applying for Paid Leave is seeking leave. Please be sure to sign the form.*

Section two: Description of the serious health condition

To be completed by a healthcare provider as defined in RCW 50A.05.010

Patient's name:	**Date of birth:** ____ / ____ / ____

Does the patient have a serious health condition? *(as defined in RCW 50A.05.010)*

☐ Yes. If yes, provide a brief description of the diagnosis: _____

_____

☐ No

Is the patient pregnant?

☐ Yes. Expected delivery date: ____ / ____ / ____ ☐ No

If yes, is the patient experiencing a pregnancy-related serious health condition?

This can include but is not limited to severe morning sickness, prenatal complications resulting in bedrest, preeclampsia, infections or recovery after a cesarean delivery or other postnatal complications.

☐ Yes ☐ No

What is the expected duration of the serious health condition?

Your answer should be your best estimate based upon your medical knowledge, experience and examination of the patient. Be as specific as you can; terms such as "unknown," or "indeterminate" may not be sufficient to determine Paid Leave eligibility.

Start date: ____ / ____ / ____

End date: ____ / ____ / ____ **or** ☐ **Condition is chronic or permanent**

PROVIDER'S INFORMATION AND CERTIFICATION

I declare under penalty of perjury that the information provided in this form is true and correct, that the patient's condition meets the definition of "serious health condition" [RCW 50A.05.010], and that I am a healthcare provider authorized to certify their condition [RCW 50A.05.010; WAC 192-500-090].

Signature *(required)*: _____ **Date** *(required)*: ____ / ____ / ____

Name and title *(required)*: _____

Certificate license number and state: _____

License area/area of practice *(required)*: _____

Business name *(required)*: _____

Address: _____

Phone number: _____

Email address: _____

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Certification of Birth Form

Who should use this form?

Parents applying for bonding leave following the birth of a child. If you are applying for family leave to bond with your child, you must provide documentation showing your child's date of birth. Documentation can include any one of the following documents:

- A copy of your child's birth certificate,
- A copy of documentation from the hospital showing your child's date of birth, or
- This form completed and signed by a healthcare provider.

Do not use this form for family leave for adoption, foster care, or other approved placement types. Visit PaidLeave.wa.gov for information about required documentation for family leave for placement.

Instructions: Provide the name and date of birth of the parent that gave birth; include their Paid Leave Customer ID number (if known). Provide the other parent's information if they are applying for leave. Have a healthcare provider complete and sign the certification of birth section. Upload the completed form or other documentation to your Paid Leave account(s) or include it with your application(s). Documentation is required for each family leave application.

Parent's information

To be completed by the parent(s) applying for leave

Information about parent that gave birth *(required)*:

Name: _____

Date of birth: ____ / ____ / ____ **Paid Leave Customer ID number** *(if known)*: _____

Information about the other parent *(optional)*:

Name: _____

Date of birth: ____ / ____ / ____ **Paid Leave Customer ID number** *(if known)*: _____

Certification of birth

To be completed by a healthcare provider as defined in RCW 50A.05.010 to certify the date of birth in order for the applicant to qualify for family leave under Paid Family and Medical Leave. Please be sure to sign the form.

Child's date of birth: ____ / ____ / ____ **Place of birth** *(city, state)*: _____

PROVIDER'S INFORMATION AND CERTIFICATION

I declare under penalty of perjury that the information provided in this form is true and correct, and that I am a healthcare provider as defined in RCW 50A.05.010.

Signature *(required)*: _____ **Date** *(required)*: ____ / ____ / ____

Name and title *(required)*: _____

Certificate license number and state: _____

License area/area of practice *(required)*: _____

Business name *(required)*: _____

Address: _____

Phone number: _____

Email address: _____