Certification forms for pregnancy & birth

**STEP 1:**
Select the right form

There are two forms in this packet. Use the **Certification of Serious Health Condition form** when you’re applying for medical leave for:
- medical care during your pregnancy
- complications related to your pregnancy
- leave to recover from giving birth
- complications related to your birth

Use the **Certification of Birth form** when you apply for leave to bond with a child born into your family.

**STEP 2:**
Fill out the form

Your healthcare provider needs to complete and sign the **Certification of Serious Health Condition form**. Healthcare provider instructions are included in this packet. Forms signed by healthcare providers more than 90 days prior to your application date will not be accepted.

Your healthcare provider, midwife, or a representative of the healthcare facility should complete and sign the **Certification of Birth form**.

Can someone else complete this form 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.
- Call us at 833-717-2273 to request a copy of the Designated Authorized Representative form.

**STEP 3:**
Upload your completed form

Upload your form in your Paid Leave benefit account or include it with your paper application.

Questions?
If you have any questions, please contact us at 833-717-2273 or paidleave@esd.wa.gov.
Instructions for Healthcare Providers

The Certification of Serious Health Condition form is used to certify a serious health condition to qualify for Paid Family and Medical Leave. Your patient may be applying due to their own serious health condition or to care for a family member with a serious health condition.

“Healthcare Provider” is defined by law in RCW 50A.05.010 and WAC 192-500-090.

SERIOUS HEALTH CONDITION

A serious health condition is defined in RCW 50A.05.010. Generally, a serious health condition could include an illness, injury, impairment, or physical or mental condition that involves:

• Inpatient care in a hospital, hospice, or residential medical care facility, including any period of incapacity; or

• Continuing treatment by a healthcare provider including any 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.
  • Pregnancy: Any period of incapacity due to pregnancy, or for 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:
    » Requires periodic visits to a health care provider;
    » Continues over an extended period of time, including recurring episodes of a single underlying condition; 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 health care 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.

FREQUENTLY ASK QUESTIONS

Visit paidleave.wa.gov/help-center, click on Healthcare Providers.
# Pregnancy and recovery from birth

## Certification of Serious Health Condition

Complete the patient information section, then have your healthcare provider complete and sign the certification.

### Patient information

<table>
<thead>
<tr>
<th>Patient’s name:</th>
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<tr>
<th>Patient’s date of birth: ___ / ___ / ___</th>
<th>Paid Leave Customer ID number (if known):</th>
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### Healthcare provider certification

To be completed and signed by a healthcare provider for leave related to pregnancy or recovery from giving birth.

- Complete either the pregnancy or recovery from birth section below.
- If your patient is experiencing incapacity related to pregnancy or birth, you must indicate so on this form so that we can approve the full amount of leave they’re entitled to.
- Give specific dates. Terms such as “unknown” or “indeterminate” won’t be sufficient to determine Paid Leave eligibility.

#### Pregnancy

The patient is (check all that apply):

- Pregnant and seeking leave for prenatal care.
- Experiencing incapacity due to a prenatal health condition. Can include but is not limited to severe morning sickness, preeclampsia, infections, or other prenatal complications.

Start date (day the patient’s leave begins):

___ / ___ / ___

End date (recovery period end date or estimated due date):

___ / ___ / ___

#### Recovery from birth

The patient is (check all that apply):

- Recovering from giving birth.
- Experiencing incapacity due to postnatal health condition. Can include but is not limited to recovery after a cesarean delivery, infections, or other postnatal complications.

Start date (baby’s date of birth):

___ / ___ / ___

End date (time needed to recover from birth and/or complications):

___ / ___ / ___

### Healthcare provider’s information and signature

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,” and that I am a healthcare provider authorized to certify their condition (RCW 50A.05.010; WAC 192-500-090).

<table>
<thead>
<tr>
<th>Signature:</th>
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Name and title:

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<tr>
<th>Certificate license number and state (optional):</th>
<th>License area/area of practice:</th>
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Phone:

Business name and address:

Email address:

Upload completed form to your Paid Leave account, include it with benefit application, or fax to 833-535-2273.
Who should use this form?

Parents applying for bonding leave following the birth of a child. Complete the parent information section, then have your healthcare provider, midwife, or a representative of your health care facility complete and sign the certification.

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.

Parents’ information

Information about parent that gave birth:

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 and signed by a healthcare provider, midwife, or a representative of a health care facility.

Child’s date of birth: _____ / _____ / _____  Place of birth (city, state): ______________________________________________

Provider’s information and signature

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, a midwife, or a representative of a healthcare facility.

Signature: ___________________________ Date: _____ / _____ / _____

Name and title: ___________________________ License area/area of practice: ___________________________

Certificate license number and state (optional): ___________________________ License area/area of practice: ___________________________

Phone: ___________________________ Business name and address: ___________________________

Email address: ___________________________

Upload completed form to your Paid Leave account, include it with benefit application, or fax to 833-535-2273.