Pregnancy & Birth Certifications

Paid Family & Medical Leave

STEP 1: Select the right form

This packet has forms for each stage of pregnancy and birth. Select the form for your circumstances. You'll need to submit an application and documentation for each type of leave you need.

Pregnancy

- Use the **Prenatal Care Medical Certification** form for applying for medical leave for medical care during your pregnancy.

Recovering from birth

- Use the **Certification of Birth** form for the first six weeks of medical leave to recover from giving birth. This form can be used for both medical leave to recover from birth and for family leave to bond with your baby.
- Use the **Medical Certification for Birth Complications** form when you need medical leave for more than six weeks to recover from birth.

Bonding with your new baby

Both parents can use the **Certification of Birth** form for family leave to bond with a child born into your family. Note, bonding leave requires a separate application.

STEP 2: Fill out the form

You complete required fields (*) in SECTION 1, and your health care provider completes SECTION 2.
Health care provider instructions are included in this packet.

STEP 3: Upload your completed form

Upload your completed form in your Paid Leave account or fax to 833-535-2273.

Certificados de embarazo y nacimiento

Permiso de cuidado pagado

PASO 1: Seleccione el formulario correcto

Este paquete tiene formularios para cada etapa del embarazo y el parto. Seleccione el formulario de acuerdo con su situación. Usted deberá enviar una solicitud y la documentación para cada tipo de permiso que necesite.

Embarazo

- Use el formulario de **Certificado médico de cuidado prenatal** para solicitar un permiso médico para la atención médica durante su embarazo.

Recuperación después del parto

- Use el formulario de **Certificado de nacimiento** durante las primeras seis semanas de permiso médico para recuperarse del parto. Este formulario se puede usar tanto para el permiso médico para recuperarse del parto como para el permiso familiar para crear lazos afectivos con su bebé.
- Use el formulario de **Certificado médico por complicaciones en el parto** cuando necesite un permiso médico de más de seis semanas para recuperarse del parto.

Crear lazos afectivos con su nuevo bebé

Ambos padres pueden usar el formulario de **Certificado de nacimiento** para el permiso familiar para crear lazos afectivos con su bebé. Tenga en cuenta que el permiso para crear lazos afectivos requiere una solicitud por separado.

PASO 2: Complete el formulario

Usted complete los campos obligatorios (*) en la SECCIÓN 1. Su proveedor de atención médica complete la SECCIÓN 2. Las instrucciones para el proveedor de atención médica se incluyen en este paquete.

PASO 3: Cargue su formulario completo

Cargue su formulario completo en su cuenta de Permiso de cuidado pagado o envíelo por fax al 833-535-2273.

Questions?

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

Washington Paid Family & Medical Leave

Instructions for Health Care Providers

"Health care provider" is defined by law in RCW 50A.05.010 and WAC 192-500-090.

Paid Leave medical certification forms are 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, their pregnancy, or to care for a family member with a serious health condition. Our Certification of Birth form can be used for the first six weeks of medical leave to recover from giving birth and for family leave to bond with a new baby.

What to do when you receive a form: Fill out Section 2. Within 7 calendar days of receipt, return the form to your patient (they will share it with us). You cannot charge a fee for completing the form.

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 health care 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.

FOR MORE INFORMATION:

Visit paidleave.wa.gov/healthcare-providers.

Questions?

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

Washington Paid Family & Medical Leave

Prenatal Care Medical Certification
Certificado médico de cuidado prenatal

Washington Paid Family & Medical Leave
Employment Security Department

Use this form when taking medical leave for prenatal care.	**Use este formulario cuando solicite un permiso médico para el cuidado prenatal.**

SECTION 1: Patient information | SECCIÓN 1: Información del paciente

Patient's name* | Nombre del paciente *:	
Date of birth (MM/DD/YYYY)*** | Fecha de nacimiento** (MM/DD/YYYY)*** :** ____ / ____ / ____	**Paid Leave Customer ID | Identificación de cliente del permiso pagado:**

SECTION 2: Health care provider certification | SECCIÓN 2: Certificado del proveedor de atención médica

To be completed and signed by a health care provider for leave related to prenatal care.

- Complete all required fields (*****). Incomplete forms may delay your patient's eligibility for benefits.
- Indicate on this form if your patient is experiencing incapacity related to pregnancy. This allows us to approve the full amount of leave they are entitled to.
- Give specific dates. Terms such as "unknown" or "indeterminate" won't be sufficient to determine Paid Leave eligibility.

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, pre-eclampsia, infections, or other prenatal complications.*

Provide the start and end dates for the leave needed due to the conditions selected above*.
Give specific dates. If leave is needed for the duration of the pregnancy, provide the estimated due date as the end date. Otherwise, the end date should be the estimated date the incapacity will no longer exist.

Start date (MM/DD/YYYY)***** : ____ / ____ / ____ **End date** (MM/DD/YYYY)*** :** ____ / ____ / ____

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

Signature* :	**Date** (MM/DD/YYYY)*** :** ____ / ____ / ___
Name and title* :	
Certificate license number and state:	**Type of practice/Specialty* :**
Phone* :	**Email address :**
Business address* :	

Certification of Birth

Certificado de nacimiento

Washington
Paid Family & Medical Leave
Employment Security Department

Use this form when taking leave for: • **The first six weeks of medical leave to recover from giving birth.** • **Family leave to bond with a child born into your family.**	**Use este formulario cuando solicite un permiso para:** • **Las primeras seis semanas de permiso médico para recuperarse del parto.** • **El permiso familiar para crear lazos afectivos con su nuevo bebé.**

SECTION 1: Parents' information | SECCIÓN 1: Información de los padres

Name of parent who gave birth* | Nombre de la persona que dio a luz*:	
Date of birth (MM/DD/YYYY)*** | Fecha de nacimiento** (MM/DD/YYYY)*** :** ____ / ____ / ____	**Paid Leave Customer ID | Identificación de cliente del permiso pagado:**
Name of non-birthing parent *(if taking leave)* **| Nombre de la persona que no dio a luz** *(si está solicitando un permiso)***:**	
Date of birth (MM/DD/YYYY)*** | Fecha de nacimiento** (MM/DD/YYYY)*** :** ____ / ____ / ____	**Paid Leave Customer ID | Identificación de cliente del permiso pagado:**

SECTION 2: Certification of birth | SECCIÓN 2: Certificado de nacimiento

To be completed and signed by a health care provider, midwife, or a representative of a healthcare facility.
Complete all required fields (*****). Incomplete forms may delay your patient's eligibility for benefits.

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

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

Signature* :	**Date** (MM/DD/YYYY)*** :** ____ / ____ / ____
Name and title* :	
Type of practice/Specialty* :	
Phone* :	**Email address :**
Business address* :	

The Employment Security Department is an equal opportunity employer/program. Auxiliary aids and services are available upon request to individuals with disabilities. Language assistance services for limited English proficient individuals are available free of charge. Washington Relay Service: 711

Medical Certification for Birth Complications
Certificado médico por complicaciones en el parto

Washington Paid Family & Medical Leave
Employment Security Department

Use this form when taking leave to recover from giving birth for more than six weeks or if you had complications. If you did not experience complications and are taking six weeks or less of leave to recover from giving birth, use the Certification of Birth form above.	**Use este formulario cuando solicite un permiso para recuperarse del parto durante más de seis semanas o si tuvo complicaciones.** Si no tuvo complicaciones y se está tomando seis semanas de permiso o menos para recuperarse del parto, use el formulario de Certificado de nacimiento que aparece arriba.

SECTION 1: Patient information | SECCIÓN 1: Información del paciente

Patient's name* | Nombre del paciente*:

Date of birth (MM/DD/YYYY)* **| Fecha de nacimiento** (MM/DD/YYYY)* **:** ____ / ____ / ____	**Paid Leave Customer ID | Identificación de cliente del permiso pagado:**

SECTION 2: Health care provider certification | SECCIÓN 2: Certificado del proveedor de atención médica

To be completed and signed by a health care provider if more than six weeks of recovery from birth is medically necessary.

- Complete all required fields (*). Incomplete forms may delay your patient's eligibility for benefits.
- Give specific dates. Terms such as "unknown" or "indeterminate" won't be sufficient to determine Paid Leave eligibility.
- Answers should be your best estimate based on your medical knowledge, experience, and examination of the patient.

Briefly describe the incapacity due to postnatal serious health condition*. *Can include but is not limited to recovery after a cesarean delivery, infections, or other postnatal complications.*

Provide the start and end dates for the leave needed for the serious health condition described above*. *Do not include bonding leave, which may be applied for separately.*

Start date (MM/DD/YYYY)* **:** ____ / ____ / ____ **End date** (MM/DD/YYYY)* **:** ____ / ____ / ____

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

Signature* :	**Date** (MM/DD/YYYY)* **:** ____ / ____ / ____
Name and title* :	
Certificate license number and state:	**Type of practice/Specialty* :**
Phone* :	**Email address :**
Business address* :	