Family Leave Certification

Paid Family & Medical Leave

STEP 1: Select the right form
Use this form when you're applying for paid **family leave** to care for a family member with a serious health condition.

STEP 2: Fill out the form
You complete required fields (*) in **SECTION 1: Paid Leave customer information**.
Your family member's health care provider completes SECTION 2: Health care provider certification. 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.

Свидетельство для оформления отпуска по семейным обстоятельствам

Программа оплачиваемого отпуска по семейным обстоятельствам и медицинским показаниям

ШАГ 1. Выберите правильную форму.
Используйте эту форму при подаче заявления на оплачиваемый **отпуск по семейным обстоятельствам** для ухода за членом семьи с серьезным заболеванием.

ШАГ 2. Заполните форму.
Вам необходимо заполнить обязательные поля (*) в **РАЗДЕЛЕ 1 «Информация об участнике программы оплачиваемого отпуска»**.
Поставщик медицинских услуг члена вашей семьи должен заполнить РАЗДЕЛ 2 «Свидетельство от поставщика медицинских услуг». Инструкции для поставщика медицинских услуг включены в этот пакет.

ШАГ 3. Отправьте заполненную форму.
Отправьте заполненную форму через свою учетную запись в системе для выплат за оплачиваемый отпуск Paid Leave или по факсу на номер 833-535-2273.

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.

Family Leave Certification - Serious Health Condition
Свидетельство для оформления отпуска по семейным обстоятельствам — серьезное заболевание

Washington Paid Family & Medical Leave
Employment Security Department

Use this form when taking leave to care for a family member who has a serious health condition.	Используйте эту форму, когда берете отпуск для ухода за членом семьи с серьезным заболеванием.

SECTION 1: Paid Leave customer information | РАЗДЕЛ 1. Информация об участнике программы оплачиваемого отпуска

Name of person applying for family leave* | Имя и фамилия лица, подающего заявление на отпуск по семейным обстоятельствам*:

Date of birth (MM/DD/YYYY)* **| Дата рождения** (ММ/ДД/ГГГГ)*: ____ / ____ / ____	**Paid Leave Customer ID | Идентификационный номер участника программы оплачиваемого отпуска:**

SECTION 2: Health care provider certification | РАЗДЕЛ 2. Свидетельство от поставщика медицинских услуг

To be completed and signed by an authorized health care provider.
Complete all required fields (*). Incomplete forms may delay your patient's eligibility for benefits.

Patient's name* :	**Patient's Date of birth** (MM/DD/YYYY)* **:**

Briefly describe the serious health condition*. Your answers should be your best estimate based on your medical knowledge, experience, and examination of the patient.

Provide the start and end dates for the leave needed due to the serious health condition described above*.
Give specific dates. Terms such as "unknown" or "indeterminate" won't be sufficient to determine Paid Leave eligibility.

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* :	