Medical Certification

گواهی مرخصی خانوادگی

Paid Family & Medical Leave

مرخصی استعلاجی و خانوادگی باحقوق

STEP 1: Select the right form
Use this form when you're applying for paid **medical leave** for your own serious health condition.

مرحله **1**: فرم صحیح را انتخاب کنید
هنگامی که بخواهید برای مراقبت از یکی از اعضای خانواده، که به بیماری/عارضه سلامتی جدی دچار است، درخواست مرخصی استعلاجی باحقوق ارائه دهید، از این فرم استفاده کنید.

STEP 2: Fill out the form
You complete required fields (*) in **SECTION 1: Patient information**.
Your health care provider completes SECTION 2: Health care provider certification. Health care provider instructions are included in this packet.

مرحله **2**: فرم را تکمیل کنید
شما فیلدهای الزامی (*) در **بخش 1** را تکمیل می‌کنید: **اطلاعات بیمار.**
ارائه‌دهنده مراقبت‌های سلامت شما بخش 2 را تکمیل می‌کند: گواهی ارائه‌دهنده مراقبت‌های سلامت. دستورالعمل‌های ویژه ارائه‌دهنده مراقبت‌های سلامت در این بسته گنجانده شده است.

STEP 3: Upload your completed form
Upload your completed form in your Paid Leave account or fax to 833-535-2273.

مرحله **3**: فرم تکمیل‌شده خود را بارگذاری کنید
فرم تکمیل‌شده را در حساب مرخصی باحقوق خود بارگذاری کنید یا آن را به شماره 833-535-2273 فکس کنید.

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

Medical Certification - Serious Health Condition
گواهی مرخصی خانواده - وضعیت جدی سلامتی

Washington
Paid Family & Medical Leave
Employment Security Department

هنگام گرفتن مرخصی استعلاجی به دلیل بیماری/عارضه سلامتی جدی خودتان، از این فرم استفاده کنید.	**Use this form when taking medical leave for your own serious health condition.**

SECTION 1: Patient information | بخش 1: اطلاعات بیمار.

Patient's name* | نام بیمار*:	
Date of birth (MM/DD/YYYY)* | تاریخ تولد (سال/روز/ماه)*: ____ / ____ / ____	**Paid Leave Customer ID** | ID متقاضی مرخصی استحقاقی باحقوق:

SECTION 2: Health care provider certification | بخش 2: گواهی ارائه‌دهنده مراقبت‌های سلامت

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.

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).

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