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.

怀孕和出生证明

带薪探亲假和病假

步骤 **1**：选择正确的表格

本套文件中含有怀孕和出生每一阶段的表格。根据您的情况选择表格。请根据您的各种休假类型提交申请和文件。

怀孕

- 请用**产前护理医疗证明**表格申请怀孕期间医疗护理的病假。

产后恢复

- 请用**出生证明**表格申请六周的产后恢复假。此表格可用于产后恢复假，也可用于与宝宝培养感情的探亲假。
- 当您需要超过六周的产后恢复假，请使用**分娩并发病症医疗证明**表格申请。

与您的新生宝宝培养感情

父母双方均可使用**出生证明**表格申请探亲假，与家中出生的孩子培养感情。请注意，培养感情假需要单独申请。

步骤 **2**：填写表格

请填写第 1 部分中的必填字段 (*)，以及您的医疗保健提供者填写第 2 部分。
本套文件中包括医疗保健提供者的说明。

步骤 **3**：上传您填妥的表格

将填妥的表格上传至您的带薪休假账户，或传真至 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

产前护理医疗证明

Washington Paid Family & Medical Leave
Employment Security Department

Use this form when taking medical leave for prenatal care.	**当您申请产前护理病假时，请使用此表格。**

SECTION 1: Patient information | 第 1 部分：患者的信息

Patient's name* | 患者姓名* :	
Date of birth (MM/DD/YYYY)* **| 出生日期** (MM/DD/YYYY)*: ____ / ____ / ____	**Paid Leave Customer ID | 带薪休假客户 ID :**

SECTION 2: Health care provider certification |第 2 部分：医疗保健提供者证明

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

出生证明

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.**	**当您申请以下休假时，请使用此表格：** • **申请六周的产后恢复假。** • **与您的家庭里出生的孩子建立关系的探亲假。**

SECTION 1: Parents' information | 第 1 部分：父母的信息

Name of parent who gave birth* | 分娩家长的姓名*：

Date of birth (MM/DD/YYYY)* **| 出生日期** (MM/DD/YYYY)*： ____ / ____ / ____	**Paid Leave Customer ID	带薪休假客户 ID：**

Name of non-birthing parent *(if taking leave)* **| 非分娩家长的姓名** *（如果休假）：*

Date of birth (MM/DD/YYYY)* **| 出生日期** (MM/DD/YYYY)*： ____ / ____ / ____	**Paid Leave Customer ID	带薪休假客户 ID：**

SECTION 2: Certification of birth | 第 2 部分：出生证明

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*:	

Medical Certification for Birth Complications

分娩并发病症医疗证明

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.	**当您请产后恢复假超过六周或出现并发症时，请使用此表。** 如果您没有出现并发症，并且正在休六周或更短的产后恢复假，请使用上述出生证明表。

SECTION 1: Patient information | 第 1 部分：患者的信息

Patient's name* | 患者姓名* :

Date of birth (MM/DD/YYYY)* **| 出生日期** (MM/DD/YYYY)* **:** ____ / ____ / ____	**Paid Leave Customer ID | 带薪休假客户 ID :**

SECTION 2: Health care provider certification | 第 2 部分：医疗保健提供者证明

To be completed and signed by a health care provider <u>if more than six weeks</u> 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* :	