

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.

懷孕及出生證明

帶薪事假及病假

第 1 步：選擇合適表格

此套裝包括懷孕和分娩各階段的表格。選擇適合您情況的表格。您需要為所需的每種休假類型提交申請和文件。

懷孕

- 使用「**產前護理醫學診斷證明**」表格申請懷孕期間醫療照護的病假。

產後恢復

- 要申請首六星期用於產後恢復的病假，可使用「**出生證明**」表格。此表格可用於申請產後恢復的病假和與新生嬰兒建立連繫的家庭假。
- 如果您需要申請六星期以上用於產後恢復的病假，請使用「**分娩併發症醫學診斷證明**」表格。

與新生嬰兒建立連繫

父母雙方都可以使用「**出生證明**」表格，以申請家庭假來與家庭的新生嬰兒建立連繫。請注意，用於建立連繫的家庭假需要單獨申請。

第 2 步：填妥表格

由你填妥第 1 部分的必填欄位 (*), 並由你的醫療服務提供者填妥第 2 部分：套裝中包括醫療服務提供者的指示。

第 3 步：上傳已填妥的表格

將填妥的表格上載至您的帶薪休假帳戶或傳真至 833-535-2273。

Questions?

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

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.

Prenatal Care Medical Certification

產前護理醫學診斷證明

Use this form when taking medical leave for prenatal care.	如您因產前護理而請病假，請使用此表格。
SECTION 1: Patient information 第 1 部分：患者資料	
Patient's name* 患者姓名* :	
Date of birth (MM/DD/YYYY)* 出生日期 (MM/DD/YYYY)* : ___ / ___ / ___	Paid Leave Customer ID 帶薪休假客戶 ID :
SECTION 2: Health care provider certification 第 2 部分：醫療服務提供者證明	
To be completed and signed by a health care provider for leave related to prenatal care.	
<ul style="list-style-type: none">• 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 <i>(check all that apply)*</i> :	
<input type="checkbox"/> Pregnant and seeking leave for prenatal care.	
<input type="checkbox"/> Experiencing incapacity due to a prenatal health condition. <i>Can include but is not limited to severe morning sickness, pre-eclampsia, infections, or other prenatal complications.</i>	
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>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).</i>	
Signature* :	Date (MM/DD/YYYY)* : ___ / ___ / ___
Name and title* :	
Certificate license number and state:	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

Certification of Birth

出生證明

Use this form when taking leave for: <ul style="list-style-type: none">• The first six weeks of medical leave to recover from giving birth.• Family leave to bond with a child born into your family.		在以下情況使用這份表格： <ul style="list-style-type: none">• 首六星期用於產後恢復的病假。• 與家庭中的新生嬰兒建立連繫的家庭假。	
SECTION 1: Parents' information 第 1 部分：患者資料			
Name of parent who gave birth* 分娩者 (家長) 姓名* :			
Date of birth (MM/DD/YYYY)* 出生日期 (MM/DD/YYYY)* : ___ / ___ / ___		Paid Leave Customer ID 帶薪休假客戶 ID :	
Name of non-birthing parent (if taking leave) 非分娩者(家長) 姓名 (如需請假) :			
Date of birth (MM/DD/YYYY)* 出生日期 (MM/DD/YYYY)* : ___ / ___ / ___		Paid Leave Customer ID 帶薪休假客戶 ID :	
SECTION 2: Certification of birth 第 2 部分：出生證明			
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>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.</i>			
Signature* :		Date (MM/DD/YYYY)* : ___ / ___ / ___	
Name and title* :			
Type of practice/Specialty* :			
Phone* :		Email address :	
Business address* :			

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Medical Certification for Birth Complications

醫學診斷證明 – 分娩併發症

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.	當申請六星期以上用於產假恢復的假期或出現併發症時，請使用此表格。如果您沒有出現併發症，並需要六星期或更短的假期來產後恢復，請使用上述的「出生證明」表格。
SECTION 1: Patient information 第 1 部分：患者資料	
Patient's name* 患者姓名* :	
Date of birth (MM/DD/YYYY)* 出生日期 (MM/DD/YYYY)* : ___ / ___ / ___	Paid Leave Customer ID 帶薪休假客戶 ID :
SECTION 2: Health care provider certification 第 2 部分：醫療服務提供者證明	
To be completed and signed by a health care provider if more than six weeks of recovery from birth is medically necessary.	
<ul style="list-style-type: none">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* :	

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