

گواهی‌های بارداری و تولد

مرخصی استعلاجی و خانوادگی

باحقوق

مرحله 1: فرم صحیح را انتخاب کنید. این بسته دارای فرم‌هایی برای هر مرحله از بارداری و تولد است. فرم را با توجه به شرایط خود انتخاب کنید. برای هر نوع مرخصی که نیاز دارید، باید درخواست و مدارکی را ارسال کنید.

بارداری

- جهت درخواست مرخصی استعلاجی برای مراقبت‌های پزشکی حین بارداری خود، از فرم **گواهی پزشکی مراقبت‌های دوران بارداری** استفاده کنید.

نقاهت پس از زایمان

- از فرم **گواهی تولد** برای شش هفته اول مرخصی استعلاجی مربوط به نقاهت پس از زایمان استفاده کنید. این فرم می‌تواند هم برای مرخصی استعلاجی مربوط به نقاهت پس از زایمان و هم برای مرخصی خانوادگی جهت تحکیم پیوند با نوزاد شما استفاده شود.
- هنگامی که به مرخصی استعلاجی به مدت بیش از شش هفته برای نقاهت پس از زایمان نیاز دارید، از فرم **گواهی پزشکی برای عوارض زایمان** استفاده کنید.

تحکیم پیوند با نوزاد جدید

هر دو والد می‌توانند از فرم **گواهی تولد** برای مرخصی خانوادگی جهت تحکیم پیوند با نوزاد متولد شده در خانواده خود استفاده کنند. توجه داشته باشید، مرخصی که صرفاً برای تحکیم پیوند باشد نیاز به درخواست جداگانه دارد.

مرحله 2:

فرم را تکمیل کنید. شما فیلدهای الزامی (*) در **بخش 1** را تکمیل می‌کنید، و ارائه‌دهنده مراقبت‌های سلامت شما **بخش 2** را تکمیل می‌کند. دستورالعمل‌های ویژه ارائه‌دهنده مراقبت‌های سلامت در این بسته گنجانده شده است.

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

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.

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

گواهی مرخصی خانوادگی

از هنگام گرفتن مرخصی استعلاجی برای مراقبت‌های دوران بارداری، از این فرم استفاده کنید.	Use this form when taking medical leave for prenatal care.
SECTION 1: Patient information بخش 1: اطلاعات بیمار	
Patient's name* نام بیمار* :	
Paid Leave Customer ID شناسه متقاضی مرخصی استحقاقی با حقوق:	Date of birth (سال/روز/سال)* تاریخ تولد (سال/روز/سال)* : ____ / ____ / ____
SECTION 2: Health care provider certification بخش 2: گواهی ارائه‌دهنده مراقبت‌های سلامت	
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 (check all that apply)*:	
<input type="checkbox"/> Pregnant and seeking leave for prenatal care.	
<input type="checkbox"/> 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>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>	
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

Certification of Birth

گواهی ولادت

هنگام گرفتن مرخصی استعلاجی برای موارد زیر، از این فرم استفاده کنید. • شش هفته اول مرخصی استعلاجی مربوط به نقاهت پس از زایمان. • مرخصی خانوادگی جهت تحکیم پیوند با نوزاد متولد شده در خانواده خود.	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.
SECTION 1: Parents' information بخش 1: اطلاعات بیمار.	
Name of parent who gave birth* نام والد زایمان کننده* :	
Paid Leave Customer ID شناسه متقاضی مرخصی استحقاقی باحقوق:	Date of birth (MM/DD/YYYY)* تاریخ تولد (سال/روز/ماه)*: ____ / ____ / ____
Name of non-birthing parent (if taking leave) نام والد غیر از والد زایمان کننده (اگر مرخصی می‌گیرد) :	
Paid Leave Customer ID شناسه متقاضی مرخصی استحقاقی باحقوق:	Date of birth (MM/DD/YYYY)* تاریخ تولد (سال/روز/ماه)*: ____ / ____ / ____
SECTION 2: Certification of birth بخش 2: گواهی ولادت	
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.	
Place of birth (city, state)* :	Child's date of birth (MM/DD/YYYY)* : ____ / ____ / ____
<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>	
Date (MM/DD/YYYY)* : ____ / ____ / ____	Signature* :
Name and title* :	
Type of practice/Specialty* :	
Email address :	Phone* :
Business address* :	

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Medical Certification for Birth Complications

گواهی پزشکی برای عوارض زایمان

Washington
Paid Family & Medical Leave

Employment Security Department

زمانی از این فرم استفاده کنید که برای دوره نقاهت پس از زایمان بیش از شش هفته مرخصی می‌گیرید یا دچار عوارض زایمان شده باشید. اگر دچار عوارض زایمان نشده‌اید و برای دوره نقاهت پس از زایمان بیش از شش هفته مرخصی می‌گیرید، از فرم گواهی تولد استفاده کنید.	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.
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SECTION 1: Patient information | بخش 1: اطلاعات بیمار

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

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

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).

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

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