

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.

លិខិតបញ្ជាក់ការមានផ្ទៃពោះ និងកំណើត

ការឈប់សម្រាកព្យាបាល និងសម្រាប់គ្រួសារ

ដែលមានប្រាក់ឈ្នួល

ជំហានទី 1 : ជ្រើសរើសទម្រង់បែបបទត្រឹមត្រូវ កញ្ចប់នេះមានទម្រង់បែបបទសម្រាប់ដំណាក់កាលនីមួយៗនៃការមានផ្ទៃពោះ និងកំណើត។ ជ្រើសរើសទម្រង់បែបបទសម្រាប់កាលៈទេសៈរបស់អ្នក។ អ្នកនឹងត្រូវការដាក់ស្នើពាក្យសុំមួយ និងឯកសារសម្រាប់ប្រភេទនីមួយៗនៃការឈប់សម្រាកដែលអ្នកត្រូវការ។

ការមានផ្ទៃពោះ

- ប្រើប្រាស់ទម្រង់បែបបទសម្រាប់ការបញ្ជាក់ផ្នែកវេជ្ជសាស្ត្រអំពីការថែទាំនៅពេលមានគភ៌ ដើម្បីដាក់ពាក្យសុំការឈប់សម្រាកព្យាបាលសម្រាប់ការថែទាំព្យាបាល អំឡុងពេលមានផ្ទៃពោះរបស់អ្នក។

ការបានស្រួលឡើងវិញពីការសម្រាលកូន

- ប្រើប្រាស់ទម្រង់បែបបទលិខិតបញ្ជាក់កំណើត សម្រាប់រយៈពេលប្រាំមួយសប្តាហ៍ដំបូងនៃការឈប់សម្រាកព្យាបាល ដើម្បីបានស្រួលឡើងវិញពីការសម្រាលកូន។ ទម្រង់បែបបទនេះអាចប្រើបានសម្រាប់ទាំងការឈប់សម្រាកព្យាបាលដើម្បីឱ្យបានស្រួលឡើងវិញពីការសម្រាលកូន និងការឈប់សម្រាកសម្រាប់គ្រួសារ ដើម្បីបង្កើតចំណងទំនាក់ទំនងជាមួយទារករបស់អ្នក។
- ប្រើប្រាស់ទម្រង់បែបបទសម្រាប់លិខិតបញ្ជាក់វេជ្ជសាស្ត្រសម្រាប់ការពិបាកពេលសម្រាល នៅពេលអ្នកត្រូវការការឈប់សម្រាកព្យាបាលរយៈពេលច្រើនជាងប្រាំមួយសប្តាហ៍ដើម្បីបានស្រួលឡើងវិញពីកំណើត។

ការចងសម្ព័ន្ធភាពជាមួយទារកថ្មីរបស់អ្នក

ទាំងឪពុកទាំងម្តាយអាចប្រើទម្រង់បែបបទលិខិតបញ្ជាក់កំណើត ដើម្បីឈប់សម្រាកសម្រាប់គ្រួសារក្នុងការបង្កើតចំណងទំនាក់ទំនងជាមួយកុមារដែលបានកើតចូលទៅក្នុងគ្រួសាររបស់អ្នក។ ចំណាំ ការឈប់សម្រាកដើម្បីបង្កើតចំណងទំនាក់ទំនងនេះ គម្រូវឱ្យមានពាក្យសុំដាច់ដោយឡែកមួយ។

ជំហានទី 2: បំពេញទម្រង់បែបបទ

អ្នកត្រូវបំពេញចន្លោះដែលបានគម្រូរ (*) នៅក្នុងផ្នែកទី 1 ហើយអ្នកផ្តល់សេវាថែទាំសុខភាពរបស់អ្នកបំពេញផ្នែកទី 2។ ការណែនាំសម្រាប់អ្នកផ្តល់សេវាថែទាំសុខភាពត្រូវបានបញ្ចូលនៅក្នុងកញ្ចប់នេះ។

ជំហានទី 3: អាប័ន្ទតទម្រង់បែបបទដែលបំពេញរួចរបស់អ្នក អាប័ន្ទតទម្រង់បែបបទដែលបំពេញរួចរបស់អ្នកនៅក្នុងគណនីឈប់សម្រាកដែលមានប្រាក់ឈ្នួលរបស់អ្នក ឬផ្ញើតាមទូរសារទៅលេខ 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



លិខិតបញ្ជាក់វេជ្ជសាស្ត្រអំពីការថែទាំនៅពេលមានភ័ក្តិ

Use this form when taking medical leave for prenatal care.	ប្រើប្រាស់ទម្រង់បែបបទនេះនៅពេលឈប់សម្រាកព្យាបាលសម្រាប់ការថែទាំនៅពេលមានភ័ក្តិ។
SECTION 1: Patient information ផ្នែកទី 1: ព័ត៌មានអ្នកជំងឺ	
Patient's name* ឈ្មោះអ្នកជំងឺ* :	
Date of birth (MM/DD/YYYY)* ថ្ងៃខែឆ្នាំកំណើត (MM/DD/YYYY)*: ___ / ___ / ___	Paid Leave Customer ID លេខសម្គាល់អតិថិជនឈប់សម្រាកដែលមានប្រាក់ឈ្នួល:
SECTION 2: Health care provider certification ផ្នែកទី 2: លិខិតបញ្ជាក់របស់អ្នកផ្តល់សេវាថែទាំសុខភាព	
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>	
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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Certification of Birth

លិខិតបញ្ជាក់កំណើត

<p>Use this form when taking leave for:</p> <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. 	<p>ប្រើប្រាស់ទម្រង់បែបបទនេះនៅពេលឈប់សម្រាកសម្រាប់៖</p> <ul style="list-style-type: none"> • ការឈប់សម្រាកព្យាបាលរយៈពេលប្រាំមួយសប្តាហ៍ដំបូងដើម្បីបានស្រួលឡើងវិញពីការសម្រាលកូន។ • ការឈប់សម្រាកក្រុមគ្រួសារ ដើម្បីបង្កើតចំណងទំនាក់ទំនងជាមួយកុមារដែលកើតរួច ចូលទៅក្នុងគ្រួសាររបស់អ្នក។
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SECTION 1: Parents' information | ផ្នែកទី 1: ព័ត៌មានឪពុកម្តាយ

<p>Name of parent who gave birth* ឈ្មោះម្តាយឪពុកដែលផ្តល់កំណើត* :</p>	
<p>Date of birth (MM/DD/YYYY)* ថ្ងៃខែឆ្នាំកំណើត (MM/DD/YYYY)* : ___ / ___ / ___</p>	<p>Paid Leave Customer ID លេខសម្គាល់អតិថិជនឈប់សម្រាកដែលមានប្រាក់ឈ្នួល:</p>
<p>Name of non-birthing parent (if taking leave) ឈ្មោះឪពុកម្តាយដែលមិនជាអ្នកផ្តល់កំណើត (ប្រសិនបើឈប់សម្រាក) :</p>	
<p>Date of birth (MM/DD/YYYY)* ថ្ងៃខែឆ្នាំកំណើត (MM/DD/YYYY)* : ___ / ___ / ___</p>	<p>Paid Leave Customer ID លេខសម្គាល់អតិថិជនឈប់សម្រាកដែលមានប្រាក់ឈ្នួល:</p>

SECTION 2: Certification of birth | ផ្នែកទី 2: លិខិតបញ្ជាក់កំណើត

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.

<p>Child's date of birth (MM/DD/YYYY)* : ___ / ___ / ___</p>	<p>Place of birth (city, state)* :</p>
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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.

<p>Signature* :</p>	<p>Date (MM/DD/YYYY)* : ___ / ___ / ___</p>
<p>Name and title* :</p>	
<p>Type of practice/Specialty* :</p>	
<p>Phone* :</p>	<p>Email address :</p>
<p>Business address* :</p>	

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Medical Certification for Birth Complications

លិខិតបញ្ជាក់វេជ្ជសាស្ត្រសម្រាប់ការពិបាកពេលសម្រាលកូន

<p>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.</p>	<p>ប្រើប្រាស់ទម្រង់បែបនេះនៅពេលអ្នកឈប់សម្រាក ដើម្បីបានស្រួលឡើងវិញពីការសម្រាលកូនសម្រាប់រយៈពេលច្រើនជាងប្រាំមួយសប្តាហ៍ ឬប្រសិនបើអ្នកមានការលំបាកនោះ។ ប្រសិនបើអ្នកមិនបានឈប់សម្រាកលំបាក ហើយនឹងឈប់សម្រាករយៈពេលប្រាំមួយសប្តាហ៍ ឬតិចជាងនេះ ដើម្បីបានស្រួលឡើងវិញពីពេលសម្រាលកូន ចូរ ប្រើប្រាស់ទម្រង់បែបបទលិខិតបញ្ជាក់កំណើតខាងលើ។</p>
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SECTION 1: Patient information | ផ្នែកទី 1: ព័ត៌មានអ្នកជំងឺ

Patient's name* ឈ្មោះអ្នកជំងឺ* :	
Date of birth (MM/DD/YYYY)* ថ្ងៃខែឆ្នាំកំណើត (MM/DD/YYYY)* : ___/___/___	Paid Leave Customer ID លេខសម្គាល់អតិថិជនឈប់សម្រាកដែលមានប្រាក់ឈ្នួល:

SECTION 2: Health care provider certification | ផ្នែកទី 2: លិខិតបញ្ជាក់របស់អ្នកផ្តល់សេវាថែទាំសុខភាព

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).

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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