

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.

임신 및 출산 증명서

유급 가족 휴가 및 병가

1단계: 올바른 양식 선택

이 패킷은 임신과 출산의 각 단계에서 필요한 양식을 수록하고 있습니다. 귀하의 상황에 맞는 양식을 선택하십시오. 필요한 휴가 유형에 맞추어 신청서와 서류 제출이 필요합니다.

임신

- 임신 중 의료를 목적으로 한 휴가를 신청하려면 **임산부 의료 증명서** 양식을 사용하십시오.

산후 조리

- 산후 조리를 위한 첫 6주 동안의 휴가에 대해서는 **출산 증명서** 양식을 사용하십시오. 이 양식은 산후 조리를 위한 병가와 아기와의 유대감을 형성하기 위한 가족 휴가에 모두 사용할 수 있습니다.
- 산후 조리를 위해 6주 이상의 병가가 필요한 경우 **출산 합병증에 대한 의료 증명서** 양식을 사용하십시오.

신생아 돌보기

부모 2명 모두 신생아를 돌보기 위한 가족 휴가 신청 시 **출산 증명서** 양식을 이용할 수 있습니다. 참고로 육아 휴가(Bonding leave)는 별도 신청이 필요합니다.

2단계: 양식 작성

섹션 1의 필수 필드(*)는 신청자가 작성하고 섹션 2는 신청자의 담당 의료 서비스 제공자가 작성합니다. 의료 서비스 제공자 지침은 본 패킷에 포함되어 있습니다.

3단계: 작성한 양식 업로드

작성한 양식을 신청자의 유급 휴가 계정에 업로드하거나 833-535-2273번으로 팩스로 보냅니다.

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

임산부 의료 증명서

Use this form when taking medical leave for prenatal care.	이 양식은 임신 중 의료를 목적으로 한 휴가를 신청할 때 사용하십시오.
SECTION 1: Patient information 섹션 1: 환자 정보	
Patient's name* 환자 이름* :	
Date of birth (MM/DD/YYYY)* 생년월일(MM/DD/YYYY)*: : ___ / ___ / ___	Paid Leave Customer ID 유급 휴가 신청자 ID:
SECTION 2: Health care provider certification 섹션 2: 의료 제공자 진단 증명	
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

출생 증명서

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.	이 양식은 다음을 목적으로 한 휴가를 신청할 때 사용하십시오. <ul style="list-style-type: none">• 산후 조리를 위한 첫 6주 동안의 휴가• 신생아를 돌보기 위한 가족 휴가
SECTION 1: Parents' information 섹션 1: 환자 정보	
Name of parent who gave birth* 출산을 한 부모의 이름* :	
Date of birth (MM/DD/YYYY)* 생년월일(MM/DD/YYYY)* : ___ / ___ / ___	Paid Leave Customer ID 유급 휴가 신청자 ID:
Name of non-birthing parent (if taking leave) 출산 당사자가 아닌 부모의 이름(휴가 신청 시) :	
Date of birth (MM/DD/YYYY)* 생년월일(MM/DD/YYYY)* : ___ / ___ / ___	Paid Leave Customer ID 유급 휴가 신청자 ID:
SECTION 2: Certification of birth 섹션 2: 출생 증명서	
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

출산 합병증에 대한 의료 증명서

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.		이 양식은 출산 후 회복을 위해 또는 출산 합병증으로 인해 6주 이상의 휴가를 신청할 때 사용하십시오. 합병증이 없고, 산후 조리를 위해 6주 또는 이 이하의 휴가를 신청하는 경우, 위에 있는 출산 증명서 양식을 사용하십시오.	
SECTION 1: Patient information 섹션 1: 환자 정보			
Patient's name* 환자 이름* :			
Date of birth (MM/DD/YYYY)* 생년월일(MM/DD/YYYY)* : ___ / ___ / ___		Paid Leave Customer ID 유급 휴가 신청자 ID:	
SECTION 2: Health care provider certification 섹션 2: 의료 제공자 진단 증명			
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*. <i>Can include but is not limited to recovery after a cesarean delivery, infections, or other postnatal complications.</i>			
Provide the start and end dates for the leave needed for the serious health condition described above*. <i>Do not include bonding leave, which may be applied for separately.</i>			
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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