

# Pregnancy & Birth

## Certifications

### 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.

# Свидетельства для оформления

## отпуска в связи с

## беременностью и рождением

## ребенка

### ШАГ 1. Выберите правильную форму.

В этом пакете собраны формы для всех этапов беременности и родов. Выберите подходящую. Нужно подавать заявление и документы для каждого типа отпуска, который вам потребуется.

#### Беременность

- Заполните форму **медицинского свидетельства о ведении беременности**, чтобы подать заявление на отпуск по медицинским показаниям для медицинского обслуживания во время беременности.

#### Восстановление после родов

- Заполните форму **подтверждения рождения**, чтобы подать заявление на отпуск по медицинским показаниям на первые шесть недель восстановления после родов. Эту форму можно использовать как для отпуска по медицинским показаниям для восстановления после родов, так и для отпуска по семейным обстоятельствам для установления связи с ребенком.
- Заполните форму **медицинского свидетельства об осложнениях при родах**, если вам требуется отпуск по медицинским показаниям на более чем шесть недель для восстановления после родов.

#### Установление связи с новорожденным ребенком

Оба родителя могут использовать форму **подтверждения рождения** для подачи заявления на отпуск по семейным обстоятельствам для установления связи с новорожденным ребенком. Примечание. Для такого отпуска нужно отдельное заявление.

### ШАГ 2. Заполните форму.

Вам необходимо заполнить обязательные поля (\*) в РАЗДЕЛЕ 1, а ваш поставщик медицинских услуг должен заполнить РАЗДЕЛ 2. Инструкции для поставщика медицинских услуг включены в этот пакет.

### ШАГ 3. Отправьте заполненную форму.

Отправьте заполненную форму через свою учетную запись в системе для выплат за оплачиваемый отпуск Paid Leave или по факсу на номер 833-535-2273.

## Questions?

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

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## 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.

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## FOR MORE INFORMATION:

Visit [paidleave.wa.gov/healthcare-providers](https://paidleave.wa.gov/healthcare-providers).

## Questions?

If you have any questions, please contact us at 833-717-2273 or [paidleave@esd.wa.gov](mailto:paidleave@esd.wa.gov).

# Prenatal Care Medical Certification

## Медицинское свидетельство о ведении беременности

<b>Use this form when taking medical leave for prenatal care.</b>	<b>Используйте эту форму, когда берете отпуск по медицинским показаниям для медицинского обслуживания во время беременности.</b>
<b>SECTION 1: Patient information   РАЗДЕЛ 1. Информация о пациенте</b>	
<b>Patient's name*   Имя и фамилия пациента*:</b>	
<b>Date of birth (MM/DD/YYYY)*   Дата рождения (MM/ДД/ГГГГ)*:</b> ___ / ___ / ___	<b>Paid Leave Customer ID   Идентификационный номер участника программы оплачиваемого отпуска:</b>
<b>SECTION 2: Health care provider certification   РАЗДЕЛ 2. Свидетельство от поставщика медицинских услуг</b>	
<b>To be completed and signed by a health care provider for leave related to prenatal care.</b>	
<ul style="list-style-type: none"><li>• Complete all required fields (*). Incomplete forms may delay your patient's eligibility for benefits.</li><li>• 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.</li><li>• Give specific dates. Terms such as "unknown" or "indeterminate" won't be sufficient to determine Paid Leave eligibility.</li></ul>	
The patient is ( <i>check all that apply</i> )*:	
<input type="checkbox"/> <b>Pregnant and seeking leave for prenatal care.</b>	
<input type="checkbox"/> <b>Experiencing incapacity due to a prenatal health condition.</b> <i>Can include but is not limited to severe morning sickness, pre-eclampsia, infections, or other prenatal complications.</i>	
<b>Provide the start and end dates for the leave needed due to the conditions selected above*.</b>	
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.	
<b>Start date (MM/DD/YYYY)* :</b> ___ / ___ / ___	<b>End date (MM/DD/YYYY)* :</b> ___ / ___ / ___
<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>	
<b>Signature* :</b>	<b>Date (MM/DD/YYYY)* :</b> ___ / ___ / ___
<b>Name and title* :</b>	
<b>Certificate license number and state:</b>	<b>Type of practice/Specialty* :</b>
<b>Phone* :</b>	<b>Email address :</b>
<b>Business address* :</b>	

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# Certification of Birth

## Подтверждение рождения

<b>Use this form when taking leave for:</b> <ul style="list-style-type: none"><li>• The first six weeks of medical leave to recover from giving birth.</li><li>• Family leave to bond with a child born into your family.</li></ul>	<b>Используйте эту форму, когда берете отпуск одного из указанных ниже типов.</b> <ul style="list-style-type: none"><li>• Отпуск по медицинским показаниям на первые шесть недель восстановления после родов</li><li>• Отпуск по семейным обстоятельствам для установления связи с новорожденным ребенком</li></ul>
<b>SECTION 1: Parents' information   РАЗДЕЛ 1. Информация о родителях</b>	
<b>Name of parent who gave birth*   Имя и фамилия родившего лица*:</b>	
<b>Date of birth (MM/DD/YYYY)*   Дата рождения (MM/ДД/ГГГГ)*:</b> ___ / ___ / ___	<b>Paid Leave Customer ID   Идентификационный номер участника программы оплачиваемого отпуска:</b>
<b>Name of non-birthing parent (if taking leave)   Имя и фамилия другого из родителей, который не рожал этого ребенка (если это лицо берет отпуск):</b>	
<b>Date of birth (MM/DD/YYYY)*   Дата рождения (MM/ДД/ГГГГ)*:</b> ___ / ___ / ___	<b>Paid Leave Customer ID   Идентификационный номер участника программы оплачиваемого отпуска:</b>
<b>SECTION 2: Certification of birth   РАЗДЕЛ 2. Подтверждение рождения</b>	
<b>To be completed and signed by a health care provider, midwife, or a representative of a healthcare facility.</b> Complete all required fields (*). Incomplete forms may delay your patient's eligibility for benefits.	
<b>Child's date of birth (MM/DD/YYYY)* : ___ / ___ / ___</b>	<b>Place of birth (city, state)* :</b>
<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>	
<b>Signature* :</b>	<b>Date (MM/DD/YYYY)* : ___ / ___ / ___</b>
<b>Name and title* :</b>	
<b>Type of practice/Specialty* :</b>	
<b>Phone* :</b>	<b>Email address :</b>
<b>Business address* :</b>	

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# Medical Certification for Birth Complications

## Медицинское свидетельство об осложнениях при родах

<p><b>Use this form when taking leave to recover from giving birth for more than six weeks or if you had complications.</b> 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><b>Используйте эту форму, когда берете отпуск для восстановления после родов на более чем шесть недель или если у вас были осложнения.</b> Если у вас не было осложнений и вы берете отпуск для восстановления после родов на шесть недель или меньший срок, используйте приведенную выше форму подтверждения рождения.</p>
<b>SECTION 1: Patient information   РАЗДЕЛ 1. Информация о пациенте</b>	
<b>Patient's name*   Имя и фамилия пациента*:</b>	
<b>Date of birth (MM/DD/YYYY)*   Дата рождения (MM/ДД/ГГГГ)*:</b> ___ / ___ / ___	<b>Paid Leave Customer ID   Идентификационный номер участника программы оплачиваемого отпуска:</b>
<b>SECTION 2: Health care provider certification   РАЗДЕЛ 2. Свидетельство от поставщика медицинских услуг</b>	
<p><b>To be completed and signed by a health care provider if more than six weeks of recovery from birth is medically necessary.</b></p> <ul style="list-style-type: none"><li>• Complete all required fields (*). Incomplete forms may delay your patient's eligibility for benefits.</li><li>• Give specific dates. Terms such as "unknown" or "indeterminate" won't be sufficient to determine Paid Leave eligibility.</li><li>• Answers should be your best estimate based on your medical knowledge, experience, and examination of the patient.</li></ul>	
<p><b>Briefly describe the incapacity due to postnatal serious health condition*.</b> <i>Can include but is not limited to recovery after a cesarean delivery, infections, or other postnatal complications.</i></p>	
<p><b>Provide the start and end dates for the leave needed for the serious health condition described above*.</b> <i>Do not include bonding leave, which may be applied for separately.</i></p>	
<b>Start date (MM/DD/YYYY)* :</b> ___ / ___ / ___	<b>End date (MM/DD/YYYY)* :</b> ___ / ___ / ___
<p><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></p>	
<b>Signature* :</b>	<b>Date (MM/DD/YYYY)* :</b> ___ / ___ / ___
<b>Name and title* :</b>	
<b>Certificate license number and state:</b>	<b>Type of practice/Specialty* :</b>
<b>Phone* :</b>	<b>Email address :</b>
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