

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.

Cadeynta Urka iyo

Dhalmada

Fasaxa Qoyska iyo Caafimaadka ee

Mushaharkiisa La Bixiyo

TALAABADA 1: Dooro foomka saxda ah

Xirmadani waxaa ku jira foomam loogu talagalay heer kasta oo uurka iyo dhalmada ah. Dooro foomka loogu talagalay xaaladahaaga. Waxaad u baahan doontaa inaad codsi iyo dukuminti ka soo gudbiso nooc kasta oo fasax ah oo aad u baahan tahay.

Uur

- Isticmaal foomka **Cadeynta Daryeelka Caafimaadka ee Kahor Dhalmada** si aad u codsato foom fasaxa caafimaadka ee daryeelka caafimaadka inta aad uurka leedahay.

Ka soo kabsashada dhalmada

- Isticmaal foomka **Cadeynta Dhalmada** lixda toddobaad ee ugu horreeya ee fasaxa caafimaadka si aad uga soo kabato dhalmada. Foomkan waxaa loo isticmaali karaa fasaxa caafimaadka si aad uga soo kabsato dhalmada iyo fasaxa qoyska si aad u xanaaneyso ilmahaaga.
- Isticmaal foomka **Cadeynta Caafimaadka ee Dhibaatooyinka Dhalmada** marka aad u baahan tahay fasax caafimaad oo ka badan lix toddobaad si aad uga soo kabsato dhalmada.

Wakhti la Qaadashada ilmahaaga dhashay

Labada waalidba waxay isticmaali karaan foomka Cadeynta Dhalmada si ay u helaan fasaxa qoyska si ay u xanaaneeyaan ilmaha u dhashay. Ogow, fasaxa wakhti la qaadashada wuxuu u baahan yahay codsi gooni ah.

TALAABADA 2: Buuxi foomka

Waxaad buuxini qeybaha loo baahanyahay (*) ee ku jira QEYBTA 1, sidoo kale daryeel bixiyahaaga caafimaad wuxuu buuxini QAYBTA 2. Tilmaamaha daryeel bixiyaha caafimaad waxay ku jirtaa baqshadan.

TALAABADA 3: Soo gali foomkaaga aad buuxisay

Gali foomkaaga aad buuxisay akoonkaaga Fasaxa Lacagta Lagu Bixiyo ama qab fakis ah ugu dir 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

Prenatal Care Caddeynta Caafimaadka



Use this form when taking medical leave for prenatal care.		Isticmaal foomkan marka aad qaadnayso fasaxa caafimaadka ee daryeelka waalidnimo	
SECTION 1: Patient information QAYBTA 1: Macluumaadka bukaanka			
Patient's name* Magaca bukaanka* :			
Date of birth (MM/DD/YYYY)* Taariikhda Dhalashada (Bisha/Maalinta/Sanadka)* : ___ / ___ / ___		Paid Leave Customer ID Fasax Mushaar leh Aqoonsiga Macamiilka:	
SECTION 2: Health care provider certification QAYBTA 2: Cadaynta Daryeel Bixiyaha Caafimaad			
<p>To be completed and signed by a health care provider for leave related to prenatal care.</p> <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. 			
<p>The patient is (check all that apply)*:</p> <p><input type="checkbox"/> Pregnant and seeking leave for prenatal care.</p> <p><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></p> <p>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.</p> <p>Start date (MM/DD/YYYY)* : ___ / ___ / ___ End date (MM/DD/YYYY)* : ___ / ___ / ___</p>			
<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>			
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

Cadaynta Dhalashada

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.	Isticmaal foomkan marka aad qaadanayso fasaxa: <ul style="list-style-type: none">• Lixda asbuuc ee ugu horayso ee fasaxa caafimaad si aad uga soo kabsato dhalmada.• Fasaxa qoyska si loo wanaajiyo xiriirka cunug laga dhalay qoyskeena
SECTION 1: Parents' information QAYBTA 1: Macluumaadka Waalidka	
Name of parent who gave birth* Magaca waalidka ilmaha dhalay* :	
Date of birth (MM/DD/YYYY)* Taariikhda Dhalashada (Bisha/Maalinta/Sanadka)* : ___ / ___ / ___	Paid Leave Customer ID Fasax Mushaar leh Aqoonsiga Macamiilka:
Name of non-birthing parent (if taking leave) Magaca waadka aan dhalihaynin (haddii fasax aad qaadanayso) :	
Date of birth (MM/DD/YYYY)* Taariikhda Dhalashada (Bisha/Maalinta/Sanadka)* : ___ / ___ / ___	Paid Leave Customer ID Fasax Mushaar leh Aqoonsiga Macamiilka:
SECTION 2: Certification of birth QAYBTA 2: Cadaynta Dhalashada	
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

Cadayenta Caafimaad ee Dhibaatooyinka

Dhalmada

<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>Isticmaal foomkan marka aad qaadnayso fasaxa si aad uga soo kabsato dhalmada ee ka badan lixda asbuuc ama haddii aad qabto dhibaato Haddii aadan la kulmin dhibaatooyin oo aad qaadato fasax dhan lix asbuuc ama ka yar si aad uga soo kabsato dhalmada, isticmaal foomka caddaynta dhalashada ee sare ku xusan.</p>	
<p>SECTION 1: Patient information QAYBTA 1: Macluumaadka bukaanka</p>			
<p>Patient's name* Magaca bukaanka* :</p>			
<p>Date of birth (MM/DD/YYYY)* Taariikhda Dhalashada (Bisha/Maalinta/Sanadka)* : ___ / ___ / ___</p>		<p>Paid Leave Customer ID Fasax Mushaar leh Aqoonsiga Macamiilka:</p>	
<p>SECTION 2: Health care provider certification QAYBTA 2AAD: Cadaynta Daryeel Bixiyaha Caafimaad</p> <p>To be completed and signed by a health care provider <u>if more than six weeks</u> of recovery from birth is medically necessary.</p> <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. 			
<p>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></p>			
<p>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></p> <p>Start date (MM/DD/YYYY)* : ___ / ___ / ___ End date (MM/DD/YYYY)* : ___ / ___ / ___</p>			
<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>			
<p>Signature* :</p>		<p>Date (MM/DD/YYYY)* : ___ / ___ / ___</p>	
<p>Name and title* :</p>			
<p>Certificate license number and state:</p>		<p>Type of practice/Specialty* :</p>	
<p>Phone* :</p>		<p>Email address :</p>	
<p>Business address* :</p>			

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