Washington
Paid Family & Medical Leave
Employment Security Department

Certification of Serious Health Condition form

Instructions for person applying for leave

Who should use this form?

The information included on this form is required when you are applying for:

- Medical leave due to your own serious health condition.
- Family leave to take care of a family member with a serious health condition.

We cannot approve your application for medical leave or family leave without certification from a healthcare provider. Upload the completed form through your Paid Leave account or include it with your application. You do not need to set up your Paid Leave account before your healthcare provider completes this form.

You may submit a complete FMLA form or similar certification to substantiate your own or your family member's serious health condition instead of this form. However, we may require additional documentation if there is a question about certification provided.

How to complete this form?

The person applying for leave completes section one, and their healthcare provider (or their family member's healthcare provider) completes section two.

The healthcare provider must be able to certify your or your family member's serious health condition. Healthcare providers who are authorized to sign this form are defined in RCW 50A.05.010 and WAC 192-500-090. Generally, "healthcare provider" means:

- A physician or an osteopathic physician who is licensed to practice medicine or surgery, as appropriate, by the state in which the physician practices;
- Nurse practitioners, nurse-midwives, midwives, clinical social workers, physician assistants, podiatrists, dentists, clinical psychologists, optometrists, and physical therapists licensed to practice under state law and who are performing within the scope of their practice as defined under state law by the state in which they practice.

Can someone else complete this form for me?

You may authorize another individual to act on your behalf for the purposes of Paid Family and Medical Leave benefits by having them complete a Designated Authorized Representative form. Your authorized representative can sign this form on your behalf with appropriate documentation. Your authorized representative cannot substitute for a healthcare provider in completing section two. Contact us at 833-717-2273 to request a copy of the form.

Questions?

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

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Instructions for healthcare providers

This form is used to certify a serious health condition in order to qualify for Paid Family and Medical Leave. Your patient may be applying due to their own serious health condition or to care for a family member with a serious health condition. Qualifying serious health conditions and authorized healthcare providers are described below. Answer each question to the best of your medical knowledge, based on your examination of the patient.

SERIOUS HEALTH CONDITION

A "serious health condition" is defined in RCW 50A.05.010 and healthcare providers should review the complete definition before certifying a patient's condition. Generally, a serious health condition could include an illness, injury, impairment, or physical or mental condition that involves:

Inpatient care: Inpatient care in a hospital, hospice, or residential medical care facility, including any period of incapacity; or

Continuing treatment by a healthcare provider: A serious health condition involving continuing treatment by a health care provider includes any one or more 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 in connection with such inpatient care.
- 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:
  - Continues over an extended period of time, including recurring episodes of a single underlying condition;
  - Requires periodic visits to a health care provider; 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.

HEALTHCARE PROVIDERS

Healthcare provider is defined in RCW 50A.05.010 and WAC 192-500-090 and means:

- A physician or an osteopathic physician who is licensed to practice medicine or surgery, as appropriate, by the state in which the physician practices;
- Nurse practitioners, nurse-midwives, midwives, clinical social workers, physician assistants, podiatrists, dentists, clinical psychologists, optometrists, and physical therapists licensed to practice under state law and who are performing within the scope of their practice as defined under state law by the state in which they practice;
- A health care provider listed above who practices in a country other than the United States, who is authorized to practice in accordance with the law of that country, and who is performing within the scope of the health care provider's practice as defined under such law; or
- Any other provider permitted to certify the existence of a serious health condition under the federal FMLA (Act Feb. 5, 1993, P.L. 103-3, 107 Stat. 6, as it existed on October 19, 2017).

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Certification of serious health condition

Instructions: Complete section one of this form, then have your or your family member's healthcare provider complete section two. Upload the completed form to your Paid Leave account or include it with your application. Please include your name on each page.

Section one: Your information

To be completed by the person applying for leave before having the healthcare provider complete section two

Paid Leave Customer ID number *(if known)***:**

Name:

Date of birth:

REASON FOR TAKING PAID FAMILY AND MEDICAL LEAVE

☐ **For my own serious health condition**

Instructions: Have your healthcare provider complete this medical certification, listing yourself as the patient.

☐ **To care for a family member during their serious health condition**

The family member needing care is my:

- ☐ Child
- ☐ Spouse or registered domestic partner
- ☐ Parent or spouse's parent
- ☐ Sibling
- ☐ Grandparent or spouse's grandparent
- ☐ Grandchild

Instructions: Have your family member's healthcare provider complete this medical certification, listing your family member as the patient.

AUTHORIZATION AND SIGNATURES

I authorize Paid Family and Medical Leave to use the information on this form to determine my eligibility for paid family or medical leave benefits and I attest that I am applying for Paid Leave due to my own serious health condition or to take care of a family member with a serious health condition.

Signature:	**Date:**

If the person applying for benefits is unable to sign this form because of a serious health condition or injury, an authorized representative may sign on their behalf, provided they also submit a Designated Authorized Representative form.

Authorized representative name:

Signature:	**Date:**

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Name of person applying for leave:_____

Section two: Description of the serious health condition

To be completed by a healthcare provider as defined in RCW 50A.05.010

Answer all questions fully and completely. Limit your responses to the condition for which the person applying for Paid Leave is seeking leave. Please be sure to sign the form.

Patient's name:	**Date of birth:** ____ / ____ / ____

Does the patient have a serious health condition that necessitates care? *(as defined in RCW 50A.05.010)*

☐ Yes ☐ No

Diagnosis:

Is the patient experiencing a serious health condition with a pregnancy that results in incapacity?

☐ Yes. Expected delivery date: _____

☐ No

What is the expected duration of the serious health condition ?

Your answer should be your best estimate based upon your medical knowledge, experience, and examination of the patient. Be as specific as you can; terms such as "unknown," or "indeterminate" may not be sufficient to determine Paid Leave eligibility.

Start date: _____ **End date:** _____

PROVIDER'S INFORMATION AND CERTIFICATION

I declare under penalty of perjury that the information provided in this form is true and correct, that the patient's condition meets the definition of "serious health condition" [RCW 50A.05.010], and that I am a healthcare provider authorized to certify their condition [RCW 50A.05.010 ; WAC 192-500-090].

Signature:	**Date:**

Name and title:

Certificate license and state:

License area/area of practice:

Business name:

Address:

Phone number:

Email address: