Medical certification for **Paid Family & Medical Leave**

STEP 1:
Select the right form

Use this form when you're applying for **medical leave** for your own serious health condition.

Forms for other leave types are in our Help Center at paidleave.wa.gov/help-center

STEP 2:
Fill out the form

The person applying for leave completes the first section, and their healthcare provider completes and signs the certification. Healthcare provider instructions are included in this packet.

Forms signed by healthcare providers more than 90 days prior to your application date will not be accepted.

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 cannot substitute for a healthcare provider in completing section two.
- Contact us at 833-717-2273 to request a copy of the Designated Authorized Representative form.

STEP 3:
Upload your completed form

Upload your form through your Paid Leave benefit account or include it with your paper application.

Instructions for **Healthcare Providers**

The Certification of Serious Health Condition form is 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 or to care for a family member with a serious health condition.

Healthcare Provider is defined by law in RCW 50A.05.010 and WAC 192-500-090.

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 healthcare 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.

FREQUENTLY ASK QUESTIONS

Visit paidleave.wa.gov/help-center, click on Healthcare Providers.

Questions?

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

Washington **Paid Family & Medical Leave**

Washington
Paid Family & Medical Leave
Employment Security Department

Medical certification

Certification of Serious Health Condition

Complete the patient information section, then have your healthcare provider complete and sign the certification.

Patient information

Patient's name:

Patient's date of birth: ____ / ____ / ____

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

Healthcare provider's certification

This section must be completed and signed by an authorized healthcare provider. **All sections are required unless otherwise noted.** Incomplete forms may delay your patient's eligibility for benefits.

Briefly describe the serious health condition. Your answers should be your best estimate based on your medical knowledge, experience, and examination of the patient.

Provide the start and end dates for the serious health condition. *Terms such as "unknown" or "indeterminate" won't be sufficient to determine Paid Leave eligibility.*

Start date: ____ / ____ / ____ End date: ____ / ____ / ____

Healthcare provider's information and signature

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," and that I am a healthcare provider authorized to certify their condition (RCW 50A.05.010; WAC 192-500-090).

Signature:

Date: ____ / ____ / 2022

Name and title:

Certificate license number and state *(optional)*:

License area/area of practice:
OB/GYN

Phone:
509.924.1990

Email address:
fmla@valobgyn.com

Business name and address:
Valley Obstetrics & Gynecology
1415 N Houk Rd Suite A Spokane Valley, WA 99216

Upload completed form to your Paid Leave account, include it with benefit application, or fax to 833-535-2273.