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

Your healthcare provider needs to complete and sign medical certification forms. Forms signed by healthcare providers more than 90 days prior to your application date will not be accepted. Healthcare provider instructions are included in this packet.

Your healthcare provider, midwife, or a representative of the healthcare facility should complete and sign the Certification of Birth form.

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.
- Call 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.

Questions?

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

Washington Paid Family & Medical Leave

Instructions for **Healthcare Providers**

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.

"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 ASKED QUESTIONS

Visit paidleave.wa.gov/help-center and 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

Prenatal Care
Medical Certification

Washington
Paid Family & Medical Leave
Employment Security Department

Use this form for:

- **Medical leave for prenatal care**
- **Medical leave related to a prenatal complication**

Patient information

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

Patient's name:	
Patient's date of birth: ____ / ____ / ____	**Paid Leave Customer ID number** *(if known)*:

Healthcare provider certification

To be completed and signed by a healthcare provider for leave related to prenatal care.

- 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.
- All sections are required unless otherwise noted. Incomplete forms may delay your patient's eligibility for benefits.

The patient is *(check all that apply)*:

☐ **Pregnant and seeking leave for prenatal care.**

☐ **Experiencing incapacity due to a prenatal health condition**. *Can include but is not limited to severe morning sickness, preeclampsia, infections, or other prenatal complications.*

Start date: *(Day the patient's leave begins)*
____ / ____ / ____

End date: *(If leave is needed for the duration of the pregnancy, provide estimated due date. Otherwise, the estimated date incapacity will no longer exist.)*
____ / ____ / ____

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:** ____ / ____ / ____
Name and title:	
Certificate license number and state *(optional)*:	**Type of practice/Specialty:**
Phone:	**Email address:**
Business name and address:	

Upload completed form to your Paid Leave account.

If you do not have an account, include the form with your benefit application or fax to 833-535-2273.

Certification of Birth

Washington
Paid Family & Medical Leave
Employment Security Department

Use this form for:

- **Family leave to bond with a child born into your family**
- **The first six weeks of medical leave to recover from giving birth**

If more than six weeks of recovery from birth is medically necessary, use the Medical Certification for Birth Complications.

Do not use this form for family leave for adoption, foster care, or other approved placement types. Visit paidleave.wa.gov for information about required documentation for family leave for placement.

Parents' information

Complete the parent information section, then have your healthcare provider, midwife, or a representative of your healthcare facility complete and sign the certification.

Information about parent that gave birth:

Name: _____

Date of birth: ____ / ____ / ____ **Paid Leave Customer ID number** *(if known)*: _____

Information about second parent *(if taking leave)*:

Name: _____

Date of birth: ____ / ____ / ____ **Paid Leave Customer ID number** *(if known)*: _____

Certification of birth

To be completed and signed by a healthcare provider, midwife, or a representative of a healthcare facility.
All sections are required unless otherwise noted. Incomplete forms may delay your patient's eligibility for benefits.

Child's date of birth: ____ / ____ / ____ **Place of birth** *(city, state)*: _____

Provider's information and signature

I declare under penalty of perjury that the information provided in this form is true and correct, and that I am a healthcare provider as defined in RCW 50A.05.010, a midwife, or a representative of a healthcare facility.

Signature:	**Date:** ____ / ____ / ____
Name and title:	
Type of practice/Specialty:	
Phone:	**Email address:**
Business name and address:	

Upload completed form to your Paid Leave account.
If you do not have an account, include the form with your benefit application or fax to 833-535-2273.

Medical Certification for Birth Complications

Washington Paid Family & Medical Leave
Employment Security Department

Use this form:

- **If more than six weeks of recovery from birth is medically necessary.**

When six weeks or less is needed to recover from giving birth, use the Certification of Birth form.

Patient information

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

Patient's name:	
Patient's date of birth: ____ / ____ / ____	**Paid Leave Customer ID number** *(if known)*:

Healthcare provider's certification

To be completed and signed by a healthcare provider <u>if more than six weeks</u> of recovery from birth is medically necessary.

- 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.
- All sections are required unless otherwise noted. Incomplete forms may delay your patient's eligibility for benefits.

Briefly describe the incapacity due to postnatal serious health condition. *Can include but is not limited to recovery after a cesarean delivery, infections, or other postnatal complications.*

Provide the start and end dates for the leave needed for the serious health condition described above. *Do not include bonding leave, which may be applied for separately.*

Start date: *(Child's date of birth)* ____ / ____ / ____ **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:** ____ / ____ / ____
Name and title:	
Certificate license number and state *(optional)*:	**Type of practice/Specialty:**
Phone:	**Email address:**
Business name and address:	

Upload completed form to your Paid Leave account.

If you do not have an account, include the form with your benefit application or fax to 833-535-2273.