

Family Leave Certification Serious Health Condition

Use this form for:

- Family leave related to caring for a family member with a serious health condition

Paid Leave customer information

Complete the customer information section, then have your family member's healthcare provider complete and sign the certification.

Name of person applying for family leave:

Date of birth: ____ / ____ / ____

Paid Leave Customer ID number (if known):

Healthcare provider certification

To 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.

Patient's name:

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 leave needed due to the serious health condition described above.

Give specific dates. 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 health care 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:

OB/GYN

Phone:

509-924-1990

Email address:

fmla@valobgyn.com

Business name and address: Valley OBGYN

1415 N Houk Rd, Ste A Spokane Valley, WA 99216

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.