Medical Certification
Serious Health Condition

Washington
Paid Family & Medical Leave
Employment Security Department

Use this form for:

- **Medical leave due to your own serious health condition**

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 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 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 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:** OB/GYN
Phone: 509-924-1990	**Email address:** fmla@valobgyn.com
Business name and address: Valley OBGYN 1415 N Houk Rd, Suite 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.