Forms for Applying for Paid Family & Medical Leave

STEP 1: Select the right form

Use the Certification of Serious Health Condition form to apply for:
• Medical leave due to your own serious health condition, including medical leave for complications during pregnancy or to recover from giving birth
• Family leave to take care of a family member with a serious health condition

Use the Certification of Birth form when applying for:
• Family leave to bond with a new child (birth, adoption or foster placement)

STEP 2: Fill out the form

The person applying for leave completes section one, and their healthcare provider (or their family member’s healthcare provider) completes section two. Healthcare provider instructions are included in this packet.

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

Submit your 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.

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

Questions?
If you have any questions, please contact us at 833-717-2273 or paidleave@esd.wa.gov.
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. Please include your name on each page. **Upload both pages to your Paid Leave account, include them with your application, or fax to 833-535-2273.**

<table>
<thead>
<tr>
<th>Section one: Your information</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>To be completed by the person applying for leave before having the healthcare provider complete section two</strong></td>
</tr>
<tr>
<td><strong>Paid Leave Customer ID number (if known):</strong></td>
</tr>
<tr>
<td><strong>Name:</strong></td>
</tr>
<tr>
<td><strong>Date of birth: _____ / _____ / ____</strong></td>
</tr>
</tbody>
</table>

**REASON FOR TAKING PAID FAMILY AND MEDICAL LEAVE**

- [ ] For my own serious health condition
  - **Instructions:** Have your healthcare provider complete page 2 of this medical certification, listing yourself as the patient.

- [ ] For medical reasons related to my own pregnancy
  - **Instructions:** Have your healthcare provider complete page 2 of this medical certification, listing yourself as the patient. If applying for family (bonding) leave following the birth of a child, you and your healthcare provider should also fill out the Certification of Birth form.

- [ ] To care for a family member during their serious health condition
  - **The family member needing care is my:**
    - [ ] Child, son-in-law, daughter-in-law
    - [ ] 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 page 2 of 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 (required):**

**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:**
Name of person applying for leave:______________________________________________________________

Instructions: 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. Return to patient or fax to 833-535-2273.

Section two: Description of the serious health condition
To be completed by a healthcare provider as defined in RCW 50A.05.010

Patient’s name: ____________________________ Date of birth: _____ / _____ / _____

Does the patient have a serious health condition? (as defined in RCW 50A.05.010)
☐ No ☐ Yes. If yes, provide a brief description of the diagnosis: ________________________________

Is the patient pregnant or recovering from giving birth?
☐ No ☐ Yes. Expected due date: _____ / _____ / _____ or Child’s date of birth: _____ / _____ / _____

If yes, is the patient experiencing a pregnancy-related serious health condition?
☐ Yes ☐ No

This can include but is not limited to severe morning sickness, prenatal complications resulting in bedrest, preeclampsia, infections or recovery after a cesarean delivery or other postnatal complications.

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: _____ / _____ / _____ or ☐ Condition is chronic or permanent

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 (required):________________________________________________________ Date (required): _____ / _____ / _____

Name and title (required):________________________________________________________

Certificate license number and state: (required):________________________________________________________

License area/area of practice (required):________________________________________________________

Business name (required):________________________________________________________

Address: (required):________________________________________________________

Phone number (required):________________________________________________________

Email address:________________________________________________________
Who should use this form?

Parents applying for bonding leave following the birth of a child. If you are applying for family leave to bond with your child, you must provide documentation showing your child’s date of birth. Documentation can include any one of the following documents:

- A copy of your child’s birth certificate,
- A copy of documentation from the hospital showing your child’s date of birth, or
- This form completed and signed by a healthcare provider.

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.

Instructions: Provide the name and date of birth of the parent that gave birth; include their Paid Leave Customer ID number (if known). Provide the other parent’s information if they are applying for leave. Have a healthcare provider complete and sign the certification of birth section. Documentation is required for each family leave application.

### Parent’s information

To be completed by the parent(s) applying for leave

Information about parent that gave birth (required):

- **Name:** __________________________________________________________________________________________
- **Date of birth:** _____ / _____ / _____  Paid Leave Customer ID number (if known): __________________________

Information about the other parent (optional):

- **Name:** __________________________________________________________________________________________
- **Date of birth:** _____ / _____ / _____  Paid Leave Customer ID number (if known): __________________________

### Certification of birth

To be completed by a healthcare provider as defined in RCW 50A.05.010 to certify the date of birth in order for the applicant to qualify for family leave under Paid Family and Medical Leave. Please be sure to sign the form.

- **Child’s date of birth:** _____ / _____ / _____  Place of birth (city, state): __________________________

### PROVIDER’S INFORMATION AND CERTIFICATION

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.

- **Signature (required):** ____________________________________________  Date (required): _____ / _____ / _____
- **Name and title (required):** _______________________________________
- **Certificate license number and state:** ________________________________
- **License area/area of practice (required):** ____________________________
- **Business name (required):** ________________________________________
- **Address:** _________________________________________________________
- **Phone number:** ___________________________________________________
- **Email address:** ___________________________________________________

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