WASHINGTON STATE UNIVERSITY
FAMILY MEDICAL LEAVE/DISABILITY LEAVE
HEALTH CARE PROVIDER STATEMENT

Please return form to: WSU Human Resource Services
Office Location: 139 French Administration Building
OR Mailing address: PO Box 641014
Pullman, WA 99163-1014
OR Fax: 509-335-1259

A EMPLOYEE COMPLETES SECTION A

EMPLOYEE INFORMATION (please print)

A complete medical certification is required to determine whether your health condition or the health condition of your family member qualifies for leave under the Family Medical Leave Act (FML) or other medical leave provisions.

Complete the Employee/Patient Information in Section A and complete Employee Name field on top of the next page. The Health Care Provider (HCP) must fully complete Section B and certify the information at Section C. It is your responsibility to ensure that the HCP completes this form and it is returned to Human Resource Services (HRS) **NOT TO YOUR DEPARTMENT** in order for HRS to review and process your request.

EMPLOYEE/PATIENT INFORMATION

Name of Employee (Last, First, MI)	Patient's relationship to employee: _____
Name of Patient (Last, First, MI)	If child, age of child _____

B HEALTH CARE PROVIDER COMPLETES SECTIONS B THROUGH C

Your patient or a family member of your patient is requesting medical leave. The specific information you provide will assist WSU in determining the appropriate leave designation. Please complete Section B and be as specific as possible; terms such as "unknown," or "as tolerated" may not be sufficient to determine their leave designation. Please fill out Section C. Failure to fully complete this form in a timely manner may lead to the delay or denial of the employee's requested leave.

Under the FML a "serious health condition" means an illness or injury, impairment, or physical or mental condition that involves one of the categories below.

Is patient's condition a "serious health condition?"

☐ Yes ☐ No

If yes, please identify any of the following that are applicable to your patient:

☐ **Inpatient care:** e.g. overnight hospital stay Date(s) of admission: _____

☐ **Incapacity of <u>more than three (3) consecutive calendar days</u> and includes:**
Two (2) or more treatments by HCP; with the first visit being within seven (7) days of the incapacity, and the second visit occurring within thirty days of the incapacity; or one treatment by HCP within seven (7) days and continuing regimen under HCP supervision.

☐ **Pregnancy:** Any period of incapacity due to pregnancy or prenatal care.

☐ **Chronic Serious Health Condition:** A chronic Serious Health Condition is one which: requires periodic visits or treatments (at least twice per year) by HCP; continues over an extended period of time; e.g. physical therapy; and may cause episodic absences rather than continued incapacity

☐ **Permanent or Long-Term Condition:** e.g. Alzheimer's disease, severe stroke, terminal stages of a disease, etc.

☐ **Multiple Treatments:** for restorative surgery, or for a condition which would likely result in an incapacitation of **<u>more than three (3) consecutive calendar days</u>** absent medical treatment (including recovery from those treatments).

Medical facts: Describe other relevant medical facts, if any, related to the condition for which the employee seeks leave. Such medical facts may include symptoms, diagnosis, or any regiment of continuing treatment, such as the use of specialized equipment.

If the leave is requested for the care of a child <u>over the age of 18</u> noted in Section A:
Is the child physically or mentally incapable of self-care? ☐ Yes ☐ No

Employee Name (Last, First, MI)

FULL-TIME LEAVE

Will the employee/patient be medically incapacitated/require care for a single period of time? ☐ Yes ☐ No

Begin date condition prevents employee/patient from working on a full time basis/requires care: ___/____/_____

Return to work date on a full-time basis/care no longer needed, if known: _____/_____/____

If return to work date unknown, date of next evaluation: _____/_____/_____

PART-TIME LEAVE

Will the employee/patient need leave/care part-time, or a reduced work schedule? ☐ Yes ☐ No

If Yes, Begin date ____/____/____ through ____/____/____ date

Identify the part-time or reduced work schedule: _____hour(s) per day; _____day(s) per week

Or describe:

INTERMITTENT LEAVE

Will the condition cause a need for intermittent/episodic absences, periodically preventing the employee from performing his/her job functions or the patient to require care? ☐ Yes ☐ No

If Yes, Begin date ____/____/____

Estimate the frequency and duration of episodic absences caused by flare-ups or follow-ups appointments (e.g. 1 time per 2 months for 3-4 days per episode)

Frequency: _____time(s) per_____ week(s)_____month(s) **Duration:** _____hour(s) or _____day(s) per episode

Identify the number of months the employee may need intermittent leave **(Select one):**

☐ 3 months ☐ 6 months ☐ 9 months ☐ 12 months ☐ Other period of time (up to 12 months) _____

Or describe:

C | HEALTH CARE PROVIDER INFORMATION

I certify that the information provided on this form is true and correct to the best of my knowledge.

Name of Health Care Provider *(please print or type)*	Health Care Provider Signature	Date
Health Care Provider Street Address	City, State, Zip	
Type of Practice	Telephone	Fax

The Genetic Information Nondiscrimination Act of 2008 (GINA) prohibits employers and other entities covered by GINA Title II from requesting or requiring genetic information of an individual or family member of the individual. To comply with this law, we are asking that you do not provide any genetic information when responding to this request for medical information. "Genetic information" as defined by GINA includes an individual's family medical history, the results of an individual's or family member's genetic tests, the fact that an individual or an individual's family member sought or received genetic services, and genetic information of a fetus carried by an individual or an individual's family member or an embryo lawfully held by an individual or family member receiving assistive reproductive services."