WASHINGTON STATE UNIVERSITY
SHARED LEAVE
HEALTH CARE PROVIDER STATEMENT

Please return form to: WSU Human Resource Services (HRS)
Office Location: 139 French Administration Building
OR Mailing Address: PO Box 641014
Pullman, WA 99163-1014
OR Fax: 509-335-1259
Questions? Call HRS at: 509-335-4521

EMPLOYEE complete sections A and B

A EMPLOYEE INFORMATION (please print)

Name (Last, First, MI)	WSU ID #

Are you requesting Shared Leave to care for a relative or household member? ☐ Yes ☐ No

If Yes:
Name of individual for whom I will provide care: _____Relationship to me: _____

B RELEASE OF MEDICAL INFORMATION

I authorize the below-named health care provider to complete this form and disclose the diagnosis, treatment and anticipated duration of relevant condition(s) to Washington State University (WSU).

Note: Information disclosed to Washington State University may be from records which are confidential and protected in accordance with RCW 70.02. State law prohibits University employees from making any further disclosure of such information without the specific written consent of the person to whom it pertains, or as otherwise permitted by law. Information concerning a client in alcohol/drug treatment is disclosed to the University from records protected by federal confidentiality rules (42 CFR Part 2). The federal rules prohibit University employees from making any further disclosure of such information without specific written consent of the person to whom it pertains, or as otherwise permitted by law. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

By law, medical information must be maintained confidentially (subject to certain limited exceptions) and separate from the employee's regular personnel records. Shared Leave medical records for all WSU employees are retained in the Human Resource Services office, in files separate from their personnel file.

By signing below I acknowledge that I have read and agree to the above.

Employee Signature	Date

HEALTH CARE PROVIDER complete sections C through G

Your patient, or a relative or household member of your patient is requesting to participate in the Shared Leave program so that they may be eligible to receive leave donations from other employees. The specific information you provide will assist WSU in determining if your patient has a condition which meets the criteria for Shared Leave. Please complete the applicable sections of this form as completely as possible to demonstrate whether the patient meets Shared Leave eligibility criteria and, if so, for what duration. Then please return this form to Human Resource Services at the contact information listed on the top of this page.

C CERTIFICATION OF SHARED LEAVE ELIGIBILITY

In accordance with RCW§41.04.665 – Washington State Leave Sharing Program, to be eligible for shared leave based on his/her condition or that of a relative or household member, a patient must be suffering from, an illness, injury, impairment, or physical or mental condition which is of an extraordinary or severe nature. Additionally, the qualifying condition must also cause or be likely to cause the employee to go on leave without pay status or terminate state employment.

The event must also prevent the employee from working for at least **five** consecutive days.

Examples of qualifying conditions may include: cancer and treatments, chemotherapy, radiation, organ transplant, major surgery requiring extended hospital stay, terminal illness/condition, fetal endangerment, or traumatic injury rendering an employee incapable of productive employment.

Does the patient have a diagnosis/condition that meets the Shared Leave criteria: ☐ Yes* ☐ No

If Yes, please complete sections **D, E, F,** and **G** and return this form to WSU Human Resource Services
*The information in sections **D**, **E**, and **F** must affirm that the employee meets Shared Leave criteria.
If No, please complete section G of this form and return both pages to WSU Human Resource Services

Employee Name (Last, First, MI)

D PATIENT EVALUATION

Pertinent diagnosis(es) (name and description of conditions)	Please describe how this diagnosis meets the definition of a severe, extreme or life threatening illness or injury.
Date condition commenced or diagnosed (mm/dd/yyyy)	Date condition expected to last until (mm/dd/yyyy)

E PLEASE PROVIDE THE BELOW ADDITIONAL INFORMATION APPLICABLE TO YOUR DIAGNOSIS

☐ Major surgery with inpatient hospital stay.	From start date ___/___/____ to end date ___/___/____
☐ Inpatient hospital stay for a severe physical or mental condition.	From start date ___/___/____ to end date ___/___/____
☐ Bed rest due to high risk pregnancy related complications (mother and/or fetal endangerment)	From start date ___/___/____ to end date ___/___/____
☐ Other treatment for condition/diagnosis described in section **D** (e.g., chemotherapy, dialysis, radiation, etc.) Please describe treatment:	From start date ___/___/____ to end date ___/___/____

F DATES WHICH CONDITION MEETS SHARED LEAVE CRITERIA PER RCW§41.04.665

Start Date ____/____/_____ through End Date ____/____/_____
OR
At minimum, meets the criteria until____/____/_____

G 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

Please return this form to WSU Human Resource Services at the contact information listed on the top of page 1.

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".