WESTERN WASHINGTON UNIVERSITY

Human Resources – Disability/Medical Leave Services
516 High Street, MS: 5221
Bellingham, WA 98225-5996
Ph: 360.650.3771
Confidential Fax: 360.788.0071

Family Medical Leave Act (FMLA)
Medical Certification – Pregnancy
(Use for Maternity or Paternity related leave)

Section I: For Completion by the EMPLOYEE

Please complete Section I before giving the form to your healthcare provider. The FMLA permits an employer to require that you submit timely and sufficient medical certification to support a request for FMLA leave protections due to the birth and care of a newborn child, to care for an immediate family member, or for a serious health condition. You are responsible for ensuring Human Resources receives timely and sufficient medical documentation in order to obtain or retain FMLA leave protections.

Employee Name: ___________________________________ Job Title: ______________________

Authorization for Release of Medical Information (for completion by patient)

I hereby authorize my healthcare provider to disclose information so that comments contained in this Medical Certification may be clarified by my employer when necessary. I understand that I have the right to withdraw this authorization at any time and that such revocation must be in writing. Further, I understand that this authorization is optional and that I am responsible for ensuring complete and sufficient information to Human Resources for the purpose of FMLA protections.

By signing below, I am providing my authorization. Without prior revocation, authorization will expire one year from the date of signature.

Patient Signature (optional): ______________________________________ Date: ________________

Patient Name (print): _____________________________ Relationship to Employee: ___________ (self/spouse)

Section II: For Completion by the HEALTHCARE PROVIDER

The employee listed above has requested leave under the FMLA following the birth of their child. Answer, fully and completely, all applicable parts below. Several questions seek a response as to the frequency or duration of a condition, treatment, etc. Your answers should be your best estimate based upon your medical knowledge, experience, and examination of the patient. Please return the completed document via fax to 360.788.0071.

Part A: MEDICAL FACTS **to be completed by healthcare provider's office only**

1) Approximate date condition commenced: _________________________________
2) Date you first treated the patient for this condition: __________________________
3) The patient is:

   - ❑ Pregnant requiring normal pre and post natal care (Due Date: ________________)
   - ❑ Experiencing pre/post natal medical complications.

   Provide relevant medical facts related to the condition of the patient (include symptoms and diagnosis):

   ____

Part B: LEAVE NEEDED **to be completed by health care provider's office only**

Healthcare provider completes applicable information regarding the employee's ability to work due to the health condition described in Part A.

Please complete if employee is patient:

Expected leave needed from work prior to birth: _____ hours per week; ____ days per month

Expected leave needed from work after birth: ____ weeks (medically necessary recovery period)

Additional Information: ____

____

Please complete if employee is patient's family member:

❑ **Is Care by the family member medically necessary?** ❑ No ❑ Yes

Estimated length of period where care by a family member will be medically necessary:

____ weeks or ____ days.

Assistance needed by the family member (mark all that apply) is:

- ❑ Basic medical
- ❑ Hygienic
- ❑ Nutritional
- ❑ Safety
- ❑ Transportation
- ❑ Provision of physical or psychological care
- ❑ Other: ____

Additional Information: ____

____

____ ________________________

Signature of Healthcare Provider **Date**

Provider Name: ____________________________________ Type of Practice/Specialty: _____________

Business Address: ____

Telephone: ______________________________ Fax: ________________________________

Please return the completed document via fax to 360.788.0071.