Family Medical Leave and Disability Services
516 High Street, MS 9054
Bellingham, WA 98225-5996
Phone: (360) 650-3771
Confidential Fax: (360) 788-0071

Medical Certification – Employee's Serious Health Condition

Please complete Section I before giving the form to your health care provider. You are responsible for ensuring Human Resources receives timely and sufficient medical documentation in order to obtain or retain FMLA leave protections due to a serious health condition. Failure to provide complete and sufficient medical certification may result in denial of your FMLA request. **Please return this form within 15 calendar days to Human Resources, not your supervisor.**

Section I: For Completion by the EMPLOYEE

Employee Name:	Job Title:

Authorization for Release of Medical Information

I hereby authorize my health care provider to complete this form and disclose diagnosis, treatment, and anticipated duration of relevant conditions to Western Washington University. 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.

Employee Signature_____ Date_____

Section II: For Completion by the HEALTH CARE PROVIDER

Your patient has requested leave under the FMLA. Answer, fully and completely, all applicable parts. Several questions seek a response as to the frequency or duration of a condition, treatment, etc. 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 "lifetime," "unknown," or "indeterminate" may not be sufficient to determine FMLA coverage. Limit your responses to the condition for which the employee is seeking leave. Do not provide information about genetic tests, as defined in 29 C.F.R. § 1635.3(f), genetic services, as defined in 29 C.F.R. § 1635.3(e), or the manifestation of disease or disorder in the employee's family members, 29 C.F.R. § 1635.3(b). Please be sure to sign the form on the last page.

Approximate date condition began:	Probable duration of condition:	Dates you treated patient for condition:

Provide relevant medical facts related to the condition (include symptoms, diagnosis, frequency of doctor visits or any regimen of continuing treatment such as the use of specialized equipment):

Was the patient admitted for an overnight stay in a hospital, hospice, or residential medical care facility? If yes, dates of admission:	❑ Yes ❑ No
Will the patient need to have treatment visits at least twice per year due to the condition?	❑ Yes ❑ No
Was medication, other than over-the-counter medication, prescribed?	❑ Yes ❑ No
Was your patient referred to other health care provider(s) for evaluation or treatment? If yes, describe the nature and expected duration of the treatments:	❑ Yes ❑ No
Based on your patient's description of their job duties, is he/she prohibited from performing one or more of the functions due to the condition? If yes, identify the job functions the employee is unable to perform:	❑ Yes ❑ No

AMOUNT OF LEAVE NEEDED

Full -Time Leave

Will the employee be incapacitated for a single continuous period of time due to his/her medical condition, including any time for treatment and recovery? ❑ Yes ❑ No

If yes, estimate the period of incapacity: Start Date: _____ End Date: _____

Part –Time Leave

Will the employee need to attend follow-up treatment appointments or work part-time or on a reduced schedule because of the employee's medical condition? ❑ Yes ❑ No

If yes, are the treatments or the reduced number of hours of work medically necessary? ❑ Yes ❑ No

Estimate treatment schedule, if any, including the dates of any scheduled appointments and the time required for each appointment, including any recovery period:

Estimate the part-time or reduced work schedule the employee needs, if any:

_____ hours per day; _____ days per week

Estimated dates reduced schedule will be needed: Start Date: _____ End Date: _____

Transition plan if employee is to slowly increase work hours to normal schedule:

Intermittent Leave

Will the condition cause episodic flare-ups preventing the employee from performing his/her job functions? ❑ Yes ❑ No

Is it medically necessary for the employee to be absent from work during episodic flare-ups? ❑ Yes ❑ No
If yes, explain:

Based upon the patient's medical history and your knowledge of the medical condition, estimate the frequency of flare-ups and the duration of related incapacity that the patient may have over the next 6 months (e.g. 1 episode every 3 months lasting 1-2 days):

Frequency: _____ times per_____ week(s) or _____ month(s)

Duration: _____ hours or _____ day(s) per episode

Health Care Provider Name	**Signature**	**Date**

Address	**City, State, Zip**

Type of Practice	**Phone**	**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, except as specifically allowed by this law. To comply with this law, we are asking that you 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.

Send completed form to confidential fax at (360) 788-0071.