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 – Maternity or Parental

Please complete Section I before giving the form to your health care provider.

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:
Patient Name:	Relationship to employee:

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

I hereby authorize my healthcare 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.

Patient Signature_____ Date_____

Section II: For Completion by the HEALTH CARE PROVIDER

Our employee is requesting pregnancy-related disability leave and/or parental leave for the birth of their child. Answer, fully and completely, all applicable parts below. Your answers should be your best estimate based upon your medical knowledge, experience, and examination of the patient.

Patient's expected delivery date: _____

Estimated length of time patient will be incapacitated due to pregnancy and delivery: _____ weeks

If employee is patient's family member, estimated period of care needed by a family member: _____ weeks/days

Additional information:

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.