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 – Shared Leave

Section I: For Completion by the EMPLOYEE	
Employee Name:	W#
Patient Name (if different from employee):	Relationship of Family Member (if not employee)
Type of leave requesting: ☐ Full-time ☐ Reduced Schedule ☐ Intermittent Leave	Dates requesting Shared Leave:
By signing below, I hereby authorize the release of my medical information to Western Washington University and allow the Human Resources (HR) Office to discuss the medical information contained on this document. My signature also authorizes the release of information about my medical condition and its expected duration. Employee Signature: _____ Date:_____	

Section II: For Completion by Health Care Provider		
The above named employee has applied for the Shared Leave Program which allows fellow employees to donate sick or vacation leave to the employee in need. To be eligible, the employee or his/her relative or household member must be a patient that is suffering from an extraordinary or severe illness, injury, impairment, or physical or mental condition which is serious, extreme, and/or life threatening which causes or is likely to cause the employee to go on leave without pay or terminate state employment. Does the patient named above have a condition that meets this criteria? ❑ Yes ❑ No		
Please describe the nature of the physical or mental condition of the patient and its effect on the employee's ability to perform his/her essential functions and/or ability to report to work:		
How does this condition meet the definition of a serious, extreme, or life threatening Illness or injury?		
Date condition commenced or diagnosed:	Probable duration of condition:	Duration leave will be needed: Start: _____ End: _____
I certify that the employee listed on this form is suffering from or has a relative or household member suffering from, an extraordinary or severe illness (serious or extreme and/or life threatening), injury, impairment, or physical or mental condition. The person's condition will remain in the "serious or extreme and/or life threatening" status for above stated duration (which may or may not include the entire recovery period).		
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. 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. 29 CFR § 1635.8(b)(1)(i)(B).

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