## Central Washington University Medical Certification of Qualifying Health Condition

Family and Medical Leave (FMLA/W-FLA)

Employee - Please complete Section 1 below (all fields required):

		Section 1	
Employee name:  Job title and department:			<ul> <li>☐ This leave is for the Employee's serious health condition or for birth/adoption of the Employee's child.</li> <li>☐ This leave is to care for a family member with a serious health condition. *Please answer questions below*</li> </ul>
Title/Dept			Name of family member for whom you will provide care:
Regular work schedule:   Monda Other: Mon, Tues, Weds, Thurs,			Relationship of family member to you:
Immediate Supervisor:			
CWU Email:			If family member is your son or daughter, date of birth:
Home Email:	<del></del>		
Home Address:	City State Zip		*Important Note: In order to take FMLA leave to care for a child over the age of 18, the child must be "incapable of self-care because of a mental or physical
Phone:	Only State Zip	,	disability" at the time FMLA leave is to commence.
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Employer Contact: CWU Human Res	sources, (509) 963-1202/	/Fax (509) 963-17	733

NOTE: The FMLA permits an employer to require that you submit a timely, complete, and sufficient medical certification to support a request for FMLA leave due to your own serious health condition. If requested by your employer, your response is required to obtain or retain the benefit of FMLA protections. Failure to provide a complete and sufficient medical certification may result in a denial of your FMLA request.

## Health Care Provider – Please complete Section 2 below:

If Employee is the patient: Complete Section 2, A and B. If Employee is NOT the patient: Complete section 2, A, B and C. Be as specific as you can; terms such as "lifetime" "unknown" or "indeterminate" may not be sufficient to determine FMLA coverage.

		Section 2			
		us health condition is an illness, injury, impairment, or physical or mental condition that involves one or more of the g. Please check all categories described that apply to the patient's condition:			
Α	□ 1.	Hospital Care: Inpatient care (i.e., an overnight stay) in a hospital, hospice or residential medical care facility, including any period of incapacity or subsequent treatment in connection with such inpatient care.			
	□ 2.	Absence Plus Treatment: A period of incapacity of more than three consecutive full calendar days (including subsequent treatment or period of incapacity relating to the same condition), that also involves:			
		<ul><li>(a) Two or more in-person treatments; the first within seven (7) days of the first day of incapacity and both within thirty (30) days of the incapacity; or</li><li>(b) One (1) in-person treatment by a health care provider which results in continuing regimen of treatment.</li></ul>			
	□ 3.	Pregnancy: Period of incapacity due to pregnancy or for prenatal care.			
	□ 4.	Chronic Serious Conditions Requiring Treatments:			
		<ul><li>(a) Require periodic visits for treatment (at least twice per year) by a health care provider;</li><li>(b) Continues over an extended period of time (including recurring episodes); and</li><li>(c) May cause episodic rather than a continuing period of incapacity (e.g., asthma, diabetes, etc.).</li></ul>			
	□ 5.	Permanent/Long-term Conditions Requiring Supervision: A period of incapacity, which is permanent or long-term due to a condition for which treatment may not be effective. The employee or family member must be under the continuing supervision of a health care provider.			
	□ 6.	Multiple Treatments (Non-Chronic): Period of absence to receive multiple treatments (including recovery) by a health care provider. Includes restorative surgery after an accident or for conditions that would likely result in a period of incapacity of more than three (3) consecutive days in the absence of treatment			

	Please provide (or attach) a brief statement of the <b>patient's</b> medical facts, including surgery, therapy, anticipated follow up visits, treatments, and referrals to other specialists for evaluation or treatment, such as physical therapist, if applicable.  IF LEFT BLANK, THIS FORM IS INCOMPLETE WHICH MAY DELAY YOUR PATIENT'S FMLA LEAVE DESIGNATION.				
В					
	State the approximate dates of the following:  Condition commenced:				
	Probable duration of the condition:				
	Probable duration of the <b>patient's</b> present incapacity (if different):				
	If the condition is pregnancy, expected delivery date:				
	Will it be necessary for the <b>employee</b> to work only intermittently or on a less than full-time schedule as a result of the condition?   Yes  No				
	If yes, how many hours per week can <b>employee</b> work?				
	What is the probable duration of the reduced schedule?				
	If the condition is chronic, will the condition cause episodic flare ups periodically preventing the <b>employee</b> from performing his/her job functions?   Yes  No				
	What is the likely frequency of episodes of incapacity? (e.g., off one day every two weeks)				
	Is the <b>employee</b> able to perform work of any kind? □ Yes □ No If yes, what work is the employee able to perform?				
С	If the <b>employee</b> will be providing care to the <b>patient</b> , indicate which category best describes the current situation:				
	<ul> <li>Provide physical care when the patient is unable to care for his/her own basic needs.</li> <li>Provide psychological comfort and reassurance to the patient.</li> </ul>				
Printe	ed Name of Health Care Provider Type of Practice				
Telep	phone Number FAX Number Email Address				
Signa	ature of Health Care Provider Date Address				

"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 employees or their family members. In order 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."