

# Medical Certification of Qualifying Health Condition Certificación Médica de una Condición de Salud Elegible Family and Medical Leave (FMLA/W-FLA) Ausencia Familiar y Médica (FMLA/W-FLA)



**EMPLOYEE – COMPLETE SECTION 1 BELOW (ALL FIELDS REQUIRED)**  
**EMPLEADO – POR FAVOR COMPLETE LA SECCIÓN 1 A CONTINUACIÓN (TODOS LOS CAMPOS SON OBLIGATORIOS)**

Employee's Name / Nombre del empleado: \_\_\_\_\_ CWU ID#: \_\_\_\_\_

Job Title and Department / Título de puesto y departamento: \_\_\_\_\_

Work Schedule: Monday through Friday, 8:00 a.m. - 5:00 p.m.  
Horario laboral: lunes a viernes, de 8:00 a. m. a 5:00 p. m.

Other: Mon/lun, Tue/mar, Wed/mié, Thur/jue,  
Fri/vie, Sat/sáb, Sun/dom \_\_\_\_\_ to/a \_\_\_\_\_  
Time/hora Time/hora

Supervisor: \_\_\_\_\_

Work Email / Correo electrónico del trabajo: \_\_\_\_\_

Home Email / Correo electrónico personal: \_\_\_\_\_

Phone / Teléfono: \_\_\_\_\_

Mailing Address / Dirección: \_\_\_\_\_

This leave is for the Employee's serious health condition or for birth/adoption of the Employee's child. / Este permiso de ausencia es debido a una condición de salud grave del empleado o por el nacimiento/adopción de un hijo del empleado.

This leave is to care for a family member with a serious health condition. **\*Please answer questions below\*** / Este permiso de ausencia es con el propósito de cuidar a un familiar con una condición de salud grave. **\*Por favor, responda las preguntas a continuación\***

Name of family member for whom you will provide care: /  
Nombre del familiar que estará cuidando: \_\_\_\_\_

Relationship of family member to you: / Relación del familiar con usted: \_\_\_\_\_

If family member is your son or daughter, date of birth: /  
Si el familiar es su hijo o hija, la fecha de nacimiento es: \_\_\_\_\_

*\*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 disability" at the time FMLA leave is to commence. / \*Nota importante: Para poder tomar el permiso de ausencia FMLA para cuidar de un hijo mayor de 18 años, el hijo deberá ser "incapaz de cuidarse a sí mismo debido a una discapacidad mental o física" en el momento en que comience el permiso de ausencia FMLA.*

**Employer Contact: CWU Human Resources, (509)963-1201/Fax (509)963-1733**  
**Contacto del Empleador: Recursos Humanos de CWU, (509)963-1201/Fax (509)963-1733**

*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. Nota: FMLA permite que un empleador le requiera presentar a tiempo una certificación médica completa y suficiente para respaldar una solicitud de permiso FMLA debido a su propia condición de salud grave. Si su empleador se lo solicita, su respuesta será requerida para poder obtener o mantener los beneficios de protección FMLA. Incumplir al no proporcionar una certificación médica completa y suficiente puede resultar en que su solicitud de FMLA sea denegada.*

## HEALTH CARE PROVIDER – PLEASE COMPLETE SECTION 2 BELOW

The employee listed above was approved for leave under the Family and Medical Leave Act (FMLA) or for a medical leave of absence if not eligible for FMLA-designated leave. Please indicate the employee's current status in regards to their availability to return to work with or without restrictions below.

**A**

A serious health condition is an illness, injury, impairment, or physical or mental condition that involves one or more of the following. Please check all categories described that apply to the patient's condition:

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:
  - (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
  - (b) One (1) in-person treatment by a health care provider which results in continuing regimen of treatment.
3. Pregnancy: Period of incapacity due to pregnancy or for prenatal care.
4. Chronic Serious Conditions Requiring Treatments:
  - (a) Require periodic visits for treatment (at least twice per year) by a health care provider;
  - (b) Continues over an extended period of time (including recurring episodes); and
  - (c) May cause episodic rather than a continuing period of incapacity (e.g., asthma, diabetes, etc.).
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

<b>B</b>	<p>Please provide (or attach) a brief statement of the patient's 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.  <b>IF LEFT BLANK, THIS FORM IS INCOMPLETE WHICH MAY DELAY YOUR PATIENT'S FMLA LEAVE DESIGNATION.</b></p>	
	<p><b>State the approximate dates of the following:</b></p> <p>Condition commenced: _____</p> <p>Probable duration of the condition: _____</p> <p>Probable duration of the patient's present incapacity (if different): _____</p> <p>If the condition is pregnancy, expected delivery date: _____</p>	
	<p><b>Will it be necessary for the employee to work only intermittently or on a less than full-time schedule as a result of the condition?</b></p> <p>If yes, how many hours per week can employee work? _____</p> <p>What is the probably duration of the reduced schedule? _____</p>	<p>Yes      No</p>
	<p><b>If the condition is chronic, will the condition cause episodic flare ups periodically preventing the employee from performing his/her job functions?</b></p> <p>What is the likely frequency of episodes of incapacity? (e.g., off one day every two weeks)</p>	<p>Yes      No</p>
	<p><b>Is the employee able to perform work of any kind?</b></p> <p>If yes, what work is the employee able to perform?</p>	<p>Yes      No</p>
<b>C</b>	<p><b>If the employee will be providing care to the patient, indicate which category best describes the current situation:</b></p> <p>Provide physical care when the patient is unable to care for his/her own basic needs.</p> <p>Provide psychological comfort and reassurance to the patient.</p>	

\_\_\_\_\_  
 Health Care Provider (Please Print)

\_\_\_\_\_  
 Type of Practice:

\_\_\_\_\_  
 Phone Number:

\_\_\_\_\_  
 Fax Number:

\_\_\_\_\_  
 Email:

\_\_\_\_\_  
 Mailing Address:

\_\_\_\_\_  
 Signature of Health Care Provider

\_\_\_\_\_  
 Date:

*"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."*