Pregnancy & Birth Certifications

Paid Family & Medical Leave

STEP 1: Select the right form

This packet has forms for each stage of pregnancy and birth. Select the form for your circumstances. You'll need to submit an application and documentation for each type of leave you need.

Pregnancy

- Use the **Prenatal Care Medical Certification** form for applying for medical leave for medical care during your pregnancy.

Recovering from birth

- Use the **Certification of Birth** form for the first six weeks of medical leave to recover from giving birth. This form can be used for both medical leave to recover from birth and for family leave to bond with your baby.
- Use the **Medical Certification for Birth Complications** form when you need medical leave for more than six weeks to recover from birth.

Bonding with your new baby

Both parents can use the **Certification of Birth** form for family leave to bond with a child born into your family. Note, bonding leave requires a separate application.

STEP 2: Fill out the form

You complete required fields (*) in SECTION 1, and your health care provider completes SECTION 2.
Health care provider instructions are included in this packet.

STEP 3: Upload your completed form

Upload your completed form in your Paid Leave account or fax to 833-535-2273.

إقرارات الحمل والولادة

إجازة أسرية وطبية مدفوعة الأجر

الخطوة **1**: اختر النموذج الصحيح

تتضمَّن هذه المجموعة نماذج كل مرحلة من مراحل الحمل والولادة. اختر النموذج المناسب لظروفك. ستحتاج إلى تقديم طلب مع الوثائق الخاصة بكل نوع من أنواع الإجازة التي ستحتاج إليها.

الحمل

- استخدمي نموذج **الإقرار الطبي لرعاية ما قبل الولادة** للتقدم بطلب الحصول على إجازة مرضية لتلقي الرعاية الطبية أثناء فترة الحمل.

التعافي من الولادة

- استخدمي نموذج **إقرار الولادة** للأسابيع الست الأولى من إجازتك المرضية للتعافي من الولادة. يمكن استخدام هذا النموذج مع كل من الإجازة المرضية للتعافي من الولادة والإجازة الأسرية لتحقيق الترابط مع طفلك.
- استخدمي نموذج **الإقرار الطبي لمضاعفات الولادة** عندما تحتاجين إلى إجازة مرضية لمدة تزيد عن ستة أسابيع للتعافي من الولادة.

تحقيق الترابط مع طفلك المولود

يمكن لكلا الوالدين استخدام نموذج **إقرار الولادة** للإجازة الأسرية من أجل تحقيق الترابط مع المولود بين أفراد الأسرة. يرجى ملاحظة أن إجازة الترابط الأسري تتطلب تقديم طلب منفصل.

الخطوة **2**: املأ النموذج

أكمِل الحقول المطلوبة (*) في القسم 1، ويُكمل مُقدِّم الرعاية الصحية المعني بك القسم 2.
ترد تعليمات مُقدِّم الرعاية الصحية في هذه الحزمة.

الخطوة **3**: حمِّل النموذج المعبأ

حمِّل النموذج المعبأ في حساب الإجازة المدفوعة الأجر الخاص بك أو أرسِله بالفاكس على الرقم 833-535-2273.

Washington
Paid Family & Medical Leave

Instructions for Health Care Providers

"Health care provider" is defined by law in RCW 50A.05.010 and WAC 192-500-090.

Paid Leave medical certification forms are used to certify a serious health condition to qualify for Paid Family and Medical Leave. Your patient may be applying due to their own serious health condition, their pregnancy, or to care for a family member with a serious health condition. Our Certification of Birth form can be used for the first six weeks of medical leave to recover from giving birth and for family leave to bond with a new baby.

What to do when you receive a form: Fill out Section 2. Within 7 calendar days of receipt, return the form to your patient (they will share it with us). You cannot charge a fee for completing the form.

SERIOUS HEALTH CONDITION

A serious health condition is defined in RCW 50A.05.010. Generally, a serious health condition could include an illness, injury, impairment, or physical or mental condition that involves:

- **Inpatient care in a hospital, hospice, or residential medical care facility, including any period of incapacity; or**
- **Continuing treatment by a health care provider including any of the following:**
  - **Incapacity:** A period of incapacity of more than three consecutive days and subsequent treatment or period of incapacity relating to the same condition. Incapacity means an inability to work, attend school, or perform other regular daily activities because of a serious health condition, treatment of that condition or recovery from it, or subsequent treatment.
  - **Pregnancy**: Any period of incapacity due to pregnancy, or for prenatal care.
  - **Chronic conditions:** Any period of incapacity or treatment for such incapacity due to a chronic serious health condition. A chronic serious health condition is one which:
    - » Requires periodic visits to a health care provider;
    - » Continues over an extended period of time, including recurring episodes of a single underlying condition; and
    - » May cause episodic rather than a continuing period of incapacity, including asthma, diabetes, and epilepsy.
  - **Permanent/Long-term**: 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, but need not be receiving active treatment by, a health care provider, including:
    - » Alzheimer's, a severe stroke, or the terminal stages of a disease; or
    - » Multiple treatments: Any period of absence to receive multiple treatments, including any period of recovery from the treatments.
    - » Substance abuse may be a serious health condition if the treatment meets other requirements in this definition.

FOR MORE INFORMATION:

Visit paidleave.wa.gov/healthcare-providers.

Prenatal Care Medical Certification

الإقرار الطبي لرعاية ما قبل الولادة

Washington Paid Family & Medical Leave
Employment Security Department

Use this form when taking medical leave for prenatal care.	**استخدمي هذا النموذج عند أخذ إجازة طبية لرعاية ما قبل الولادة.**

SECTION 1: Patient information | القسم 1: معلومات المريض

Patient's name* **اسم المريض*** **:** |

Date of birth (MM/DD/YYYY)* **تاريخ الميلاد** (شهر/يوم/سنة)* **:** | ____ / ____ / ____	**Paid Leave Customer ID** | **معرّف عملاء الإجازة المدفوعة الأجر:**

SECTION 2: Health care provider certification | القسم 2: إقرار مُقدِّم الرعاية الصحية

To be completed and signed by a health care provider for leave related to prenatal care.

- Complete all required fields (*****). Incomplete forms may delay your patient's eligibility for benefits.
- Indicate on this form if your patient is experiencing incapacity related to pregnancy. This allows us to approve the full amount of leave they are entitled to.
- Give specific dates. Terms such as "unknown" or "indeterminate" won't be sufficient to determine Paid Leave eligibility.

The patient is *(check all that apply)**:*

☐ **Pregnant and seeking leave for prenatal care.**

☐ **Experiencing incapacity due to a prenatal health condition**. *Can include but is not limited to severe morning sickness, pre-eclampsia, infections, or other prenatal complications.*

Provide the start and end dates for the leave needed due to the conditions selected above*.
Give specific dates. If leave is needed for the duration of the pregnancy, provide the estimated due date as the end date. Otherwise, the end date should be the estimated date the incapacity will no longer exist.

Start date (MM/DD/YYYY)* : ____ / ____ / ____ **End date** (MM/DD/YYYY)* **:** ____ / ____ / ____

I declare under penalty of perjury that the information provided in this form is true and correct, that I have read and understand the definition of a serious health condition, that the patient's condition meets the definition of "serious health condition," and that I am a health care provider authorized to certify their condition (RCW 50A.05.010; WAC 192-500-090).

Date (MM/DD/YYYY)* **:** ____ / ____ / ___	**Signature* :**
Name and title* :	
Type of practice/Specialty* :	**Certificate license number and state:**
Email address :	**Phone* :**
Business address* :	

Certification of Birth

Washington Paid Family & Medical Leave
Employment Security Department

إقرار الميلاد

Use this form when taking leave for: • **The first six weeks of medical leave to recover from giving birth.** • **Family leave to bond with a child born into your family.**	**استخدمي هذا النموذج عند أخذ إجازة لمدة:** • **الأسابيع الست الأولى من إجازتكِ المرضية للتعافي من الولادة.** • **طلب إجازة عائلية للارتباط بطفل وُلد في عائلتك.**

SECTION 1: Parents' information | القسم 1: معلومات ولي الأمر

Name of parent who gave birth* | اسم الأم التي أنجبت* :

Date of birth (MM/DD/YYYY)* **تاريخ الميلاد**	**Paid Leave Customer ID معرّف عملاء الإجازة المدفوعة الأجر: |**
(شهر/يوم/سنة)* : ____ / ____ / ____	

Name of non-birthing parent *(if taking leave)* **اسم الأم التي لم تنجب** *(في حال طلب إجازة)* **| :**

Date of birth (MM/DD/YYYY)* **تاريخ الميلاد**	**Paid Leave Customer ID معرّف عملاء الإجازة المدفوعة الأجر: |**
(شهر/يوم/سنة)* : ____ / ____ / ____	

SECTION 2: Certification of birth | القسم 2: إقرار الميلاد

To be completed and signed by a health care provider, midwife, or a representative of a healthcare facility.
Complete all required fields (*). Incomplete forms may delay your patient's eligibility for benefits.

Place of birth (city, state)* :	**Child's date of birth** (MM/DD/YYYY)* : ____ / ____ / ____

I declare under penalty of perjury that the information provided in this form is true and correct, and that I am a health care provider as defined in RCW 50A.05.010, a midwife, or a representative of a healthcare facility.

Date (MM/DD/YYYY)* : ____ / ____ / ___	**Signature* :**
Name and title* :	
Type of practice/Specialty* :	
Email address :	**Phone* :**
Business address* :	

Medical Certification for Birth Complications
الإقرار الطبي لمضاعفات الولادة

Washington Paid Family & Medical Leave
Employment Security Department

استخدمي هذا النموذج عند أخذ إجازة للتعافي من الولادة لمدة تزيد عن ستة أسابيع أو إذا تعرضتِ لمضاعفات. إذا لم تتعرَّضي لأي مضاعفات وتحتاجين إلى إجازة لمدة ستة أسابيع أو أقل للتعافي من الولادة، فاستخدمي نموذج إقرار الميلاد المذكور أعلاه.	**Use this form when taking leave to recover from giving birth for more than six weeks or if you had complications.** If you did not experience complications and are taking six weeks or less of leave to recover from giving birth, use the Certification of Birth form above.

SECTION 1: Patient information | القسم 1: معلومات المريض

Patient's name* **اسم المريض*** **:** |

Date of birth (MM/DD/YYYY)* **تاريخ الميلاد** (شهر/يوم/سنة)* **:** ____ / ____ / ____	**Paid Leave Customer ID** **معرّف عملاء الإجازة المدفوعة الأجر:**

SECTION 2: Health care provider certification | القسم 2: إقرار مُقدِّم الرعاية الصحية

To be completed and signed by a health care provider if more than six weeks of recovery from birth is medically necessary.

- Complete all required fields (*). Incomplete forms may delay your patient's eligibility for benefits.
- Give specific dates. Terms such as "unknown" or "indeterminate" won't be sufficient to determine Paid Leave eligibility.
- Answers should be your best estimate based on your medical knowledge, experience, and examination of the patient.

Briefly describe the incapacity due to postnatal serious health condition*. *Can include but is not limited to recovery after a cesarean delivery, infections, or other postnatal complications.*

Provide the start and end dates for the leave needed for the serious health condition described above*. *Do not include bonding leave, which may be applied for separately.*

Start date (MM/DD/YYYY)* **:** ____ / ____ / ____ **End date** (MM/DD/YYYY)* **:** ____ / ____ / ____

I declare under penalty of perjury that the information provided in this form is true and correct, that I have read and understand the definition of a serious health condition, that the patient's condition meets the definition of "serious health condition," and that I am a health care provider authorized to certify their condition (RCW 50A.05.010; WAC 192-500-090).

Date (MM/DD/YYYY)* **:** ____ / ____ / ____	**Signature* :**
Name and title* :	
Type of practice/Specialty* :	**Certificate license number and state:**
Email address :	**Phone* :**
Business address* :	