Please return form to: EWU Benefits Office
Fax: 509-359-2874 Benefits
Office Location: 318 Showalter Hall Cheney, WA 99004
Questions? Call 509-359-4300

HEALTH CARE PROVIDER MEDICAL CERTIFICATION FOR PREGNANCY AND CHILDBIRTH RELATED DISABILITY

A EMPLOYEE COMPLETES SECTION A

Complete the EMPLOYEE/PATIENT information in Section A. The Health Care Provider (HCP) must fully complete Section B and certify the information at Section C. It is your responsibility to ensure the completed form is returned to Benefits Office to process your leave request.

EMPLOYEE/PATIENT INFORMATION(please print)

Name of Employee (Last, First, MI):	(If applicable) Patient's relationship to employee: ________________________

Name of Patient (if not employee) for whom care will be provided (Last, First, MI):

B HEALTH CARE PROVIDER COMPLETES SECTIONS B & C

Your patient or a family member of your patient is requesting medical leave. The specific information you provide will assist Eastern Washington University in determining the appropriate leave designation. Please complete Section B and be as specific as possible; terms such as “unknown,” or “as tolerated” may not be sufficient to determine their leave designation. Please fill out Section C. Failure to fully complete this form in a timely manner may lead to the delay or denial of the employee’s requested leave.

Expected date of delivery for your patient: ____/____/____(mm/dd/yy)

FULL-TIME/CONTINUOUS LEAVE:

Expected dates of patient’s physical incapacity due to pregnancy and delivery (generally 6 weeks post-delivery {8 weeks for C-Section} unless other complications arise).
Please DO NOT include period for baby bonding/parental leave. ONLY include time for recovery from childbirth.

Will the employee/patient be medically incapacitated/require care for a single period of time? Yes No

Begin date of period of incapacity: ____/____/____ End date of period of incapacity: ____/____/____

REDUCED WORK SCHEDULE:

Will the employee need a reduced work schedule? Yes No

If Yes, Begin date: ____/____/____ through end date: ____/____/____

Identify the part-time/reduced work schedule that is medically necessary: ______hour(s) per day; ______day(s) per week

C HEALTH CARE PROVIDER INFORMATION

I certify that the information provided on this form is true and correct to the best of my knowledge.

Health Care Provider Name *(please print or type)*	Health Care Provider Signature	Date
Health Care Provider Street Address	City, State, Zip	
Type of Practice	Telephone	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 do 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.”