UNIVERSITY *of* WASHINGTON
OFFICE OF ACADEMIC PERSONNEL
Academic Human Resources

Parental Leave Certification for Parent Other than the Birth Mother

To employee - complete the following information on every page:	
Employee name:	
Employee EID:	
Department:	
Employee phone:	Employee email:

To Employee: Complete Part 1 and arrange for your family's health care provider or appropriate agency to complete Part 2. **Return all sections of the completed form as soon as possible but no later than 15 calendar days from the start of your leave.** Contact Academic Human Resources if you believe that you will not be able to return the completed form within the specified time period.

PART 1 – to be completed by employee (please print)

I am requesting time off work ☐No ☐Yes

From (date) ____________ to (date) ____________

I am requesting a reduced work schedule as follows ☐No ☐Yes

_____ hours/day for _______ days/seek until (date) ___________

I am requesting an intermittent work schedule ☐No ☐Yes If yes, describe requested schedule:

I am requesting to use paid sick leave if I am eligible ☐No ☐Yes

Note: Parental leave for anyone other than the birth mother is unpaid unless time off is needed to provide care for the birth mother or newborn/newly adopted child's serious health condition. If requesting leave for your family member's serious health condition, complete the Leave Request for Family Member's Serious Health Condition form.

Employee Signature ______________________________ Date ____________

PART 2 – to be completed by Health Care Provider, Adoption Agency or Foster Care Agency

Our employee is requesting time off from work or a modified work schedule as the parent (other than the birth mother) of a newborn child, or of a newly placed, adopted, or foster child. Please provide the information requested below. The Genetic Information Non-discrimination 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, except as specifically allowed by this law. 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.

For Adoptive or Foster Parents, Adoption or Foster Care Agency

Anticipated date of adoption or of becoming a foster parent:

Provider information

Name of Agency or Organization (please print) ______________________________

Provider Name (please print) ______________________________

Business Address ______________________________ Phone ____________

Provider Signature ______________________________ Date ____________

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For Birth Parent, Health Care Provider	
Expected date of baby's delivery	Expected dates during which the birth mother is considered temporarily incapacitated due to pregnancy and delivery. From (date) ____________ to (date) ____________

Birth mother's Health Care Provider information

Provider name (please print) ____

Business address ______________________________________ Phone ____________

Provider Signature ______________________________ Date ______________

Return to:
Academic Human Resources
Box 351270
Seattle, WA 98195-1270
Phone (206) 543.5630 Fax (206) 221.4622
acadpers@uw.edu

AHR USE ONLY
FMLA Eligible: ___No ___Yes
Total days requested:________
Reviewed by (initials):________Date:________