

Whitman County Human Resources

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CERTIFICATION OF HEALTH CARE PROVIDER

Employee's Name (Print): _____

Patient's Name (if different from employee): _____

1. Condition description and prognosis: _____

2. If the condition described above is for a patient other than the employee, describe the care required by the employee:

3. The employee needs leave. It may begin on _____ and end on _____

4. The leave must be: _____ Continuous _____ Occasional (as permitted by condition)

5. If intermittent, please explain: _____

6. Can the employee return to work on a regular and reliable basis with certain accommodations?

NO

YES

7. If yes, what accommodations would be needed for the employee to return to work on a regular and reliable basis:

8. How long will the employee need the accommodations suggested? _____

Health Care Provider Signature: _____

Name of Health Care Provider (Print): _____

Type of Practice: _____

Address: _____

Date: _____

To be completed by the employee needing leave to care for a family member:

Please attach a statement describing the care you will provide and an estimate of the period during which you will provide it, including a schedule if leave is to be taken intermittently.

I acknowledge that my family member is in the care of the above provider and is being treated for the condition listed above. Furthermore, I acknowledge that I will be providing the care described herein.

Employee Signature: _____ Date: _____

GINA Notification: 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, 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.