### If you or a relative/household member suffers from an extraordinary or severe illness, injury, impairment, or physical or mental condition, this form must be completed by a Licensed Physician/Health Care Practitioner in addition to the Shared Leave Request form. Once this form has been completed, please send it directly to your assigned Human Resource (HR) Consultant via fax: 360-507-9250. This release expires 90 days from the date of signature.

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| **OPTIONAL**: By signing below, I hereby authorize the release of my medical information, related to this request, to the Department of Enterprise Services and allow the Human Resources (HR) Office to discuss, with the Health Care Practitioner or designee, the medical information contained on this document. My signature also authorizes the release of information about my medical condition and its expected duration. | |
| Employee Signature: | Date: |

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| Employee Name (Please Print): | Location: |
| Position Title: | Supervisor: |
| **\*If requesting Shared Leave to care for a relative or household member, please provide the following:** | |
| Patient Name: | Relationship to Employee: |

**Attending Licensed Physician / Health Care Practitioner:**

Theanswers provided below should be based on your medical knowledge, experience, and examination of the patient**. Be as specific as you can**; terms such as “lifetime,” “unknown,” or “indeterminate” may not be sufficient for us to approve the employee’s request for leave.

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| 1. Please describe the nature of the physical or mental condition and its effect on the employee’s ability to perform their essential functions and/or ability to report to work. | |
| 1. Please identify the beginning date the physical or mental condition commenced or will cause the employee to be absent from work: | |
| 1. In your medical opinion, is the physical or mental condition an extraordinary or severe illness, injury or impairment that you would consider serious, extreme, and or life threatening?   Yes  No | |
| If **yes**, please indicate if this employee will be absent:  Full Time  Part-Time  Intermittently | Anticipated Duration: |

|  |  |
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| **Licensed Health Care Provider (PRINTED) name and title:** | **Contact Phone Number:** |
| **Licensed Health Care Provider signature:** | **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 an individual or family member of the individual. 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. 29 CFR § 1635.8(b)(1)(i)(B).