This form must be completed by a licensed physician/health care practitioner. Once this form has been completed, please FAX to 509.682.6441, or mail in a confidential envelope to Wenatchee Valley College, Human Resources at 1300 Fifth St, Wenatchee WA 98801. If you have questions, please call 509.682.6444.

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| Employee Name (please print): | Department/Division: | |
| **If requesting Shared Leave to care for a relative or household member, please provide the following:** | | |
| Patient Name: (print) | Relationship to Employee: | |
| By signing below, I hereby authorize release of the medical information requested below to the appropriate human resources representative at Wenatchee Valley College. | | |
| Employee ‘s signature or (**for care of /family/household member) family member’s signature**: | | Date: |

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| **ATTENDING LICENSED PHYSICIAN / HEALTH CARE PRACTITIONER** |
| Wenatchee Valley College grants shared leave when appropriate for **extraordinary, severe or life threatening physical or behavioral health conditions**. ***Some examples are****:* ***heart attack; stroke; major surgery; severe behavioral health conditions.***  *In addition, we grant shared leave for* ***pregnancy disability*** *meaning pregnancy-related medical or miscarriage.* Your answers provided below should be based on your medical knowledge, experience, and examination of the patient**. Be as specific as you can**; terms such as “unknown” may not be sufficient for us to make a shared leave decision.  *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).*   1. Describe the relevant medical facts related to the condition for which the employee is seeking shared leave.**Please describe the effects of the condition on the employee’s ability to perform the essential functions of their job and/or ability to report to work**. If there is a treatment plan in place, please describe the treatment plan (e.g., chemotherapy, dialysis, radiation, etc.). ***If this pertains to the employee’s family/household member****, please describe the type of care our employee will provide to the family member and* ***why our employee’s presence is necessary to provide that care during their work hours****.*   *\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*  *\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_* |

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| **ATTENDING LICENSED PHYSICIAN / HEALTH CARE PRACTITIONER (continued)** |
| 2. **Check** **all that apply**:  Major surgery (with inpatient hospital stay) and recovery period requiring continuous leave from work.  Provide dates of hospitalization: \_\_\_\_\_\_\_/\_\_\_\_\_\_/\_\_\_\_\_\_ to \_\_\_\_\_\_/\_\_\_\_\_\_/\_\_\_\_\_\_  Anticipated Return to Work Date: \_\_\_\_\_\_\_/\_\_\_\_\_\_/\_\_\_\_\_\_  Outpatient surgery for severe or life threatening condition with recovery period requiring continuous leave from work:  Date of Surgery: \_\_\_\_\_\_\_/\_\_\_\_\_\_/\_\_\_\_\_\_; Anticipated Return to Work Date: \_\_\_\_\_\_\_/\_\_\_\_\_\_/\_\_\_\_\_\_;  Critical or catastrophic illness or injury (*considered to be life-threatening*) that required hospitalization and/or requires a prolonged treatment continuum and/or recovery;  Provide dates of hospitalization: \_\_\_\_\_\_\_/\_\_\_\_\_\_/\_\_\_\_\_\_ to \_\_\_\_\_/\_\_\_\_\_\_/\_\_\_\_\_\_;  Anticipated Return to Work Date: \_\_\_\_\_\_\_/\_\_\_\_\_\_/\_\_\_\_\_\_;  Severe behavioral health condition that required in-patient hospital stay or resulted in an ongoing behavioral health treatment program (inpatient or day) requiring continuous leave from work;  Provide date(s) of hospitalization or dates of treatment program \_\_\_\_\_\_/\_\_\_\_\_\_/\_\_\_\_\_\_ to \_\_\_\_\_\_\_/\_\_\_\_\_\_/\_\_\_\_\_\_;  Anticipated Return to Work Date: \_\_\_\_\_\_\_/\_\_\_\_\_\_/\_\_\_\_\_\_;  Bed rest due to high risk pregnancy-related complications (mother and/or fetal endangerment).  Other relevant information:  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

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| **ATTENDING LICENSED PHYSICIAN / HEALTH CARE PRACTITIONER INFORMATION** | |
| \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Licensed Healthcare Provider Name (please print)  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Title  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Phone | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Name of Facility or Organization  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Address  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  City, State, Zip |
| \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Licensed Healthcare Provider Signature Date | |

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