City of Tacoma
Human Resources Department

Shared Leave Medical Certificate

To apply for shared leave this form must be completed by a Licensed Physician/Health Care Practitioner.

Once this form has been completed, please send it directly to:
The Disability and Leave Management Office, City of Tacoma Human Resources Department
747 Market Street 1420 Tacoma, WA 98402 • Fax: (253) 591-5451 • Email Address: DLM@cityoftacoma.org

EMPLOYEE'S INFORMATION	
Employee Name (Please Print):	Department:
Position Title:	Supervisor:
By signing below, I hereby authorize the release of my medical information, related to this request, to the Department of City of Tacoma and allow the Disability and Leave Management Office (HR) 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:

The City of Tacoma's Shared Leave Program is intended to allow employees to assist each other with leave donations to help cope with severe, extreme and/or life threatening health crises. Donated leave is intended to help employees in these circumstances to bridge an unexpected prolonged absence that they do not have paid leave to cover and which would cause them to go into unpaid status for a period of time.

Examples of "extraordinary or severe" situations that are typically approved include:
Major surgery with inpatient hospital stay; outpatient surgery for severe condition; cancer and treatment; hospitalization for a severe physical or mental condition; enrollment in an ongoing behavioral health treatment program (inpatient or day) requiring continuous leave from work; bed rest due to high risk pregnancy-related complications.

Conditions that are typically not approved include:
Flu; chicken pox; sprained ankle; elective cosmetic surgery; intermittent leave for chronic, ongoing medical conditions.

ATTENDING LICENSED PHYSICIAN / HEALTH CARE PRACTITIONER

Your patient is asking you to disclose information about themselves so that the City of Tacoma's Disability and Leave Management Office can process a request to receive leave donations from other employees. The qualification criteria to receive shared leave are explained in the section above. The information you provide will be used to determine whether the medical condition meets the criteria for receiving shared leave.

The 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 "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, which will likely to require a prolonged absence.

2. 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

Provide additional information regarding your diagnosis by checking all of the following that apply:	**Start Date**	**End Date**
☐ Major surgery with inpatient hospital stay		
☐ Outpatient surgery for a severe condition		
☐ Hospitalization for severe physical or mental condition		
☐ Enrollment in an ongoing behavioral health treatment program (inpatient or day) requiring continuous leave from work		
☐ Bed rest due to high risk pregnancy-related complications (mother and/or fetal endangerment)		
☐ Treatment for condition described above (e.g., chemotherapy, dialysis, radiation etc.)		

Notes:

3. Please indicate if this employee will be absent: ☐ Full Time ☐ Part-Time ☐ Intermittently

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).