Mass General Brigham

Parental Leave
Health Care Provider Certification Form

SECTION 1: For Completion by the EMPLOYEE

1. Employee Name & ID: _____
First Middle Last Employee ID#

2. Requested Leave Start Date: _____ / _____ / _____ Estimated Return to Work Date: _____ / _____ / _____

3. Patient name: _____
First Middle Last

4. Is the person listed above your spouse: Yes_____ No_____

5. Does the individual in section 3 work at MGB? Yes_____ No_____

SECTION 2: For Completion by EMPLOYEE'S Spouse's or Partner's HEALTH CARE PROVIDER

Please do not provide information about genetic tests, as defined in 29 C.F.R. § 1635.3(f), genetic services, as defined in 29 C.F.R. § 1635.3(e), or the manifestation of disease or disorder in the employee's family members, 29 C.F.R. § 1635.3(b).

1. **DIAGNOSIS:** _____

Expected Delivery Date: _____ / _____ / _____

Provider Signature: _____ **Date:** _____

Print Name: _____ **Address:** _____

Practice/Specialty: _____ **Phone:** _____

Once completed fax this form to the leave coordinator at 617-726-1887
Questions? Please contact Ask myHR at 833-275-6947 or submit an online request at askmyhrportal.com

Last Updated: Jan 10, 2020