TheStandard®

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Standard Insurance Company
866.756.8116 Tel 866.751.5174 Fax
PO Box 3877 Portland OR 97208

Applying For Washington Paid Family And Medical Leave (WA PFML)

To Use Washington Paid Family And Medical Leave To:
Care for a family member with a serious health condition

Complete Form WA PFML-1
- ☐ Complete WA PFML-1, Part A
- ☐ Provide WA PFML-1 to employer
- ☐ Employer completes WA PFML-1, Part B and returns to you within 3 days

Complete Form WA PFML-3
- ☐ Care recipient completes WA PFML-3 and provides to health care provider
- ☐ Care recipient's health care provider keeps WA PFML-3

Complete Form WA PFML-4
- ☐ Complete "Employee" information at the top of WA PFML-4
- ☐ Provide WA PFML-4 to care recipient's health care provider
- ☐ Care recipient's health care provider completes WA PFML-4 and returns to you

Send forms and documents
- ☐ Send completed forms and supporting documentation to The Standard
- ☐ The Standard accepts or denies claim within 14 days

Please keep a copy of all pages for your records.

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Request For Washington Paid Family And Medical Leave (Form WA PFML-1) Instructions

- To request Washington Paid Family And Medical Leave (WA PFML), the employee requesting WA PFML must complete Part A of the *Request For Washington Paid Family And Medical Leave* (Form WA PFML-1). All items on the form are required unless noted as optional. The employee then provides the form to the employer to complete Part B.
- The employer completes Part B of the *Request For Washington Paid Family And Medical Leave* (Form WA PFML-1) and returns it to the employee within three days.
- Additional forms are required depending on the type of leave being requested. The employee requesting leave is responsible for the completion of these forms.
- The employee submits the completed *Request For Washington Paid Family And Medical Leave* (Form WA PFML-1) with the required additional form to The Standard. The employee should retain a copy of each submitted form for their records.

PART A - EMPLOYEE INFORMATION (to be completed by the employee)

The employee requesting WA PFML must complete all required information.

Washington Paid Family And Medical Leave (WA PFML) Request (to be completed by the employee)

Question 10: Family member means a child, grandchild, grandparent, parent, sibling, or spouse of an employee.
Child includes a biological, adopted, or foster child, a stepchild, child's spouse, or a child to whom the employee stands in loco parentis, is a legal guardian, or is a de facto parent, regardless of age or dependency status.
Grandchild means a child of the employee's child.
Grandparent means a parent of the employee's parent.
Parent means the biological, adoptive, de facto, or foster parent, stepparent, or legal guardian of an employee or the employee's spouse, or an individual who stood in loco parentis to an employee when the employee was a child.
Spouse means a husband or wife or state registered domestic partner.

Question 11: If dates are "Continuous", the employee must provide the start and end dates of the requested WA PFML. These dates should be the actual dates that the WA PFML will begin and end. If uncertain, estimate the start and end dates and indicate "Dates are estimated". If dates are "Periodic", enter the dates WA PFML will be taken. Please be as specific as possible. If the dates are unknown or estimated, indicate "Dates are estimated".

If dates are estimated, The Standard may require you to submit a request for payment after the WA PFML day is taken. Payment for approved claims will be due as soon as possible but in no event more than 14 days from the date of the completed request.

Question 12: Date employer was notified. If the employee is submitting the WA PFML request to their employer with less than 30 days' advance notice from the start date of the WA PFML, the employee must explain why 30 days' notice could not be given. If the explanation will not fit in the space provided on the form, enter "See Attached" and add an attachment with the explanation. Be sure to include the employee's full name and their date of birth at the top of the attachment.

Employment Information (to be completed by the employee)

Question 14: Enter the date of hire to the best of the employee's recollection. If it has been more than a year since the date of hire, entering the year in which employment started is sufficient.

Question 18: List all other income you will be receiving while on WA PFML. Include the type/name of income and how much. Example PTO from employer for $500.00 a week.

If you are pre-submitting form: Indicate if the employee is pre-submitting their WA PFML request. Pre-submitting is defined as submitting the application in advance of an upcoming qualifying event, with certain required information missing due to the information being unknown at the time of the submitting. If pre-submitting is permitted by The Standard, the missing information must be supplied as soon as it is known. Benefits cannot be determined until all of the required information is provided.

The Standard will provide the employee a notice within five days which 1) states the claim is pending; 2) identifies what information is missing; 3) instructs how to submit the missing information. **Once all information is supplied, The Standard has 14 days to pay or deny the claim.**

If The Standard does not permit pre-submitting, The Standard must return the Request for Washington Paid Family And Medical Leave within five days to the employee with an explanation that the claim should be re-submitted when all information is available.

Employee signs and dates, before giving this form to their employer to complete Part B.

PART B - EMPLOYER INFORMATION (to be completed by the employer)

The employer of the employee requesting WA PFML must complete all information in Part B.

Question 2: If a Social Security Number is used for the Federal Employer Identification Number (FEIN), enter the Social Security Number.

Question 8. You can call the state or check through the employer portal for this information.

"Wage" or "wages" means: For the purpose of payment of benefits, the remuneration paid by one or more employers to an employee for employment during the employee's qualifying period.

"Employee's average weekly wage" means the quotient derived by dividing the employee's total wages during the two quarters of the employee's qualifying period in which total wages were highest by twenty-six. If the result is not a multiple of one dollar, we will round the result to the next lower multiple of one dollar.

Question 9. You can call the state or check through the employer portal for this information. The state will have hours from all employers the employee has worked. Typical workweek hours means: (a) For an hourly employee, the average number of hours worked per week by an employee since the beginning of the qualifying period; and (b) Forty hours for a salaried employee, regardless of the number of hours the salaried employee typically works.

For salaried employees, the number of hours worked in a week are assumed to be forty, regardless of how many hours are actually worked. Typical workweek hours are determined by multiplying the number of weeks in the qualifying period the employee held the salaried position by forty, adding any other hours that were not salaried, if any, and then dividing that amount by fifty-two. For all other employees, typical workweek hours are determined by dividing the sum of all hours reported in the qualifying period by fifty-two.

Qualifying period means the first four of the last five completed calendar quarters or, if eligibility is not established, the last four completed calendar quarters immediately preceding the application for leave.

Affirmation employee is eligible for WA PFML: To be eligible for any family and medical leave, an employee must be in employment in the state of WA for eight hundred twenty hours during the qualifying period, by an employer with a voluntary plan or an employer utilizing the state family and medical leave plan. An employee qualifies for benefits under an employer's voluntary plan after the employee works at least three hundred forty hours for the current employer, unless this requirement is waived by the employer.

Employer signs and dates, and then returns to the employee requesting WA PFML within three business days.

Be sure to complete the appropriate additional WA PFML form(s) based on the type of WA PFML leave being requested.

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Request For Washington Paid Family And Medical Leave (Form WA PFML-1)

TO BE COMPLETED BY THE EMPLOYEE

Employee's name (first name, middle initial, last name)	Employee's date of birth (MM/DD/YYYY)

PART A - EMPLOYEE INFORMATION (to be completed by the employee)

1. Employee's legal name (first name, middle initial, last name)	2. Other last names, if any, under which employee has worked

3. Employee's mailing address Street	City	State	Zip Code	Country (if not USA)

4. Employee's Social Security Number or TIN	5. Employee's date of birth (MM/DD/YYYY)	6. Employee's primary telephone number ( )

7. Employee's preferred email address while on WA PFML (if available)	8. Employee's gender ☐ Male ☐ Female ☐ Not designated/Other

9. Reason for WA PFML request: ☐ Bond with child ☐ Care for family member ☐ Military qualifying event ☐ Own serious health condition

10. The family member is employee's: ☐ Child (biological, adopted, foster, stepchild or child's spouse) ☐ Spouse or registered domestic partner ☐ Sibling ☐ Parents and legal guardians (or spouse's parent) ☐ Grandparent (or spouse's grandparent) ☐ Grandchild

11. Will WA PFML be for a continuous period of time and/or periodic?

☐ Continuous _____ / _____ / _____ _____ / _____ / _____ ☐ Dates are estimated
WA PFML start date (MM/DD/YYYY) WA PFML end date (MM/DD/YYYY)

Identify dates periodic WA PFML will be taken:

☐ Periodic _____ ☐ Dates are estimated

12. Date employer was notified. If providing less than 30 day's advance notice to the employer, please explain:

Employment Information (to be completed by the employee)

13. Business name	14. Employee's date of hire (MM/DD/YYYY)

15. Employee's work location Street address

City	State	Zip code	Country (if not U.S.A.

16. Employer's telephone number for contact regarding this request. ( )	17. Is employee currently receiving Workers' Compensation Lost Wage Benefits? ☐ Yes ☐ No

18. List pay you will be receiving while on WA PFML, source of pay and amount.

19. Have you taken any leave in the last 52 weeks? ☐ Yes ☐ No	20. If yes list dates and type of leave.

Disclosure statement: Information regarding WA PFML benefits received by the employee, such as payments received and types of leave, will be provided to the employer.

Declaration and signature

An individual is disqualified for benefits for any week he or she has knowingly and willfully made a false statement or representation involving a material fact or knowingly and willfully failed to report a material fact and, as a result, has obtained or attempted to obtain any benefits under the Washington Paid Family And Medical Leave Law.

I am hereby making a request for paid family and medical leave benefits under the Washington State Paid Family And Medical Leave Law. My signature affirms that the information I am providing is true and accurate to the best of my knowledge and belief.

Employee's signature	Date signed (MM/DD/YYYY)

☐ I am submitting this form in advance (see instructions about pre-submitting). I understand the insurance carrier will contact me to advise how to submit the required missing information.

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Request For
Washington Paid Family And Medical Leave
(Form WA PFML-1)

TO BE COMPLETED BY THE EMPLOYEE

Employee's name (first name, middle initial, last name)	Employee's date of birth (MM/DD/YYYY)

PART B - EMPLOYER INFORMATION (to be completed by the employer)

1. Business's full legal name and mailing address			
Mailing address			
City	State	Zip code	Country (if not U.S.A.)
2. Employer's FEIN			
3. UBI Number	4. Employer's contact name for questions related to WA PFML		
5. Employer's contact telephone number ( )	6. Employer's contact email address	7. Employee's date of hire (MM/DD/YYY)	
8. Employee's Average Weekly Wage as provided by Washington state for WA PFML			
9. Employee's Typical Work Week Hours as provided by Washington state for WA PFML			
10. Check Days Normally Worked ☐ Monday ☐ Tuesday ☐ Wednesday ☐ Thursday ☐ Friday ☐ Saturday ☐ Sunday			
10a. Is employee hourly or salaried? ☐ Hourly ☐ Salaried			
11a. When reporting employee wages to the state of Washington, do you include sick leave, PTO, or any other income as wages? ☐ Yes ☐ No			
11b. If yes which ones?			
12. What type of paid benefits will the employee receive while on WA PFML?			
13. Is the employee taking federal Family Medical Leave Act (FMLA) concurrently with WA PFML? ☐ Yes ☐ No	14. WA PFML policy number		
WA PFML insurance carrier's name and mailing address **Standard Insurance Company** **PO Box 3877** **Portland, OR 97208** **866-751-5174 Fax**			

Declaration and signature

☐ I affirm the employee meets the eligibility for Washington Paid Family And Medical Leave, unless I have waived this requirement.

I am the person authorized to sign as the employer of the employee requesting WA PFML. My signature affirms that to the best of my knowledge and belief, the information I have provided is true and accurate.

Employer's authorized signature	Date signed (MM/DD/YYYY)
Title	

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Washington Paid Family And Medical Leave
Release Of Personal Health Information
For Family Member
(Form WA PFML-3)

- If an employee is requesting Washington Paid Family And Medical Leave (WA PFML) to care for a family member with a serious health condition, the care recipient or an authorized representative must complete a *Release Of Personal Health Information For Family Member* (Form WA PFML-3) and submit it to their health care provider, along with a copy of the *Certification For Care Of Family Member* (Form WA PFML-4).
- The *Release Of Personal Health Information For Family Member* (Form WA PFML-3) enables the health care provider to complete *Certification For Care Of Family Member* (Form WA PFML-4) and release it to the employee seeking WA PFML benefits.
- Before completing and signing, the care recipient must read the *Release Of Personal Health Information For Family Member* (Form WA PFML-3) in its entirety.
- The employee requesting WA PFML submits both the *Request For Washington Paid Family And Medical Leave* (Form WA PFML-1) and the *Certification For Care Of Family Member* (Form WA PFML-4) to their employer's WA PFML insurance carrier, for WA PFML benefit determination.

  NOTE: This form will be retained by the health care provider. The employee should make a copy for their records before giving it to the health care provider.

Care recipient or authorized representative signs and dates.

This form is given to the care recipient's health care provider along with the *Certification For Care Of Family Member* (Form WA PFML-4).

RELEASE OF PERSONAL HEALTH INFORMATION BY THE HEALTH CARE PROVIDER FOR A FAMILY MEMBER WITH A SERIOUS HEALTH CONDITION (to be completed by the care recipient or authorized representative and submitted to care recipient's health care provider with Form WA PFML-4)

Employee enters their name, and care recipient's (patient's) name and date of birth at the top of each page.

The WA PFML insurance carrier name requested at the top of the form is the same as the WA PFML insurance carrier identified in *Request For Washington Paid Family And Medical Leave* (Form WA PFML-1) Part B line 13.

Care recipient or authorized representative must complete all applicable requested information.

If a care recipient is unable to fill out this form, an authorized representative must attach a copy of legal documentation, such as a health care proxy or power of attorney, permitting the representative to sign on behalf of the care recipient. The health care provider will require this documentation of authorization unless the authorized representative is a parent signing on behalf of a minor child.

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Washington Paid Family And Medical Leave
Release Of Personal Health Information
For Family Member
(Form WA PFML-3)

TO BE COMPLETED BY THE EMPLOYEE

Employee's legal name (first name, middle initial, last name)	
Patient's Name	Patient's date of birth (MM/DD/YYYY))
Relationship of patient to employee	If patient is employee's son or daughter, date of birth (MM/DD/YYYY)

RELEASE OF PERSONAL HEALTH INFORMATION BY THE HEALTH CARE PROVIDER FOR A FAMILY MEMBER WITH A SERIOUS HEALTH CONDITION (to be completed by the care recipient or authorized representative and submitted to care recipient's health care provider with Form WA PFML-4)

I, _____ , authorize my health care provider listed on this form to
Care recipient's (patient's) legal name

release my personal health information to _____ and their
Employee's legal name

employer's WA PFML insurance carrier Standard Insurance Company.

Records Subject to Release: This form gives the health care provider listed permission to include information from your health care records on the attached medical certification. This form gives your health care provider permission to release only the information in your health care records that relate to your current condition, which is the subject of the employee's request for Washington Paid Family And Medical Leave benefits.

Duration of Revocable Release: This authorization ends after one year, or when you revoke the release. You can cancel this release at any time. To cancel, send a letter to the health care provider listed on this form.

This form does NOT allow your health care provider to release the following types of information, unless you specifically permit such release. Put an "X" next to any information your health provider MAY release:

☐ HIV/AIDS related information ☐ Mental health information ☐ Alcohol/drug treatment ☐ Psychotherapy notes

Health Care Provider Information (to be completed by the care recipient or authorized representative)

Identify the health care provider who is currently providing you with treatment for a condition that is subject to the employee's request for WA PFML benefits.

1. Health care provider's name

2. Health care provider's mailing address Mailing Address

City	State	Zip Code	Country (if not U.S.A.)

3. Health care provider's telephone number (provide area or country code)
( )

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Washington Paid Family And Medical Leave
Release Of Personal Health Information
For Family Member
(Form WA PFML-3)

TO BE COMPLETED BY THE EMPLOYEE

Employee's legal name (first legal name, middle initial, last name)	
Care recipient's (patient's) legal name (first name, middle initial, last name)	Care recipient's (patient's) date of birth (MM/DD/YYYY)

RELEASE OF PERSONAL HEALTH INFORMATION BY THE HEALTH CARE PROVIDER FOR A FAMILY MEMBER WITH A SERIOUS HEALTH CONDITION (to be completed by the care recipient or authorized representative and submitted to care recipient's health care provider with Form WA PFML-4)

Care Recipient Information (to be completed by the care recipient or authorized representative)

4. Care recipient's mailing address Mailing address			
City	State	Zip Code	Country (if not U.S.A.)
5. Care recipient's Social Security Number		6. Care recipient's telephone number (provide area or country code) ( )	

READ AND SIGN BELOW

I hereby request that the health care provider listed give a completed *Health Care Provider Certification For Care Of Family Member With Serious Health Condition* (Form WA PFML-4) to the employee identified on Form WA PFML-4, I understand that such information includes a diagnosis and prognosis of my current condition, the date it commenced, and any estimation of the amount of care that I require from the employee requesting WA PFML benefits as a result of my current condition.

Care recipient's signature	Date signed (MM/DD/YYYY)

Authorized representative

I, _____ , represent the care recipient in this matter as authorized by:
Print legal name

☐ Parental right ☐ Power of attorney (attach copy) ☐ Court order (attach copy) ☐ Health care proxy (attach copy)

Authorized representative's signature	Date signed (MM/DD/YYYY)

The employee should retain a copy for their own records.

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Washington Paid Family And Medical Leave Certification For Care Of Family Member (Form WA PFML-4) Instructions

To Be Completed by Employee

INSTRUCTION to the EMPLOYEE: **The employee requesting Washington Paid Family And Medical Leave (WA PFML) to care for family member with a serious health condition must submit the *Certification For Care Of Family Member* (Form WA PFML-4) with *Request For Paid Family and Medical Leave* (Form WA PFML-1). Fill out the employee information of this form and give to the health care provider along with *Release Of Personal Health Information For Family Member* (Form WA PFML-3). When you receive the completed *Certification For Care Of Family Member* (Form WA PFML-4) from the healthcare provider, send the completed forms and supporting documentation to the The Standard.**

Employee's Name				
Employee's Address	City	State	ZIP	Phone No.
Patient's Name	Relationship of patient to employee	If patient is employee's son or daughter, date of birth		
Patient's Address	City	State	ZIP	Phone No.

To Be Completed By Health Care Provider

INSTRUCTIONS for HEALTH CARE PROVIDERS

This form is used to certify a serious health condition in order to qualify for WA PFML. Qualifying serious health conditions and authorized healthcare providers are described below. Answer each question to the best of your medical knowledge, based on your examination of the patient.

SERIOUS HEALTH CONDITION

A "serious health condition" is defined in RCW 50A.05.010 and healthcare providers should review the complete definition before certifying a patient's condition. Generally, a serious health condition could include an illness, injury, impairment, or physical or mental condition that involves:

Inpatient care: Inpatient care in a hospital, hospice, or residential medical care facility, including any period of incapacity; or

Continuing treatment by a healthcare provider: A serious health condition involving continuing treatment by a health care provider includes any one or more of the following:

- Incapacity: A period of incapacity of more than three consecutive days and subsequent treatment or period of incapacity relating to the same condition. Incapacity means an inability to work, attend school, or perform other regular daily activities because of a serious health condition, treatment of that condition or recovery from it, or subsequent treatment in connection with such inpatient care.
- Pregnancy: Any period of incapacity due to pregnancy, or for prenatal care;
- Chronic conditions: Any period of incapacity or treatment for such incapacity due to a chronic serious health condition. A chronic serious health condition is one which:
  - Continues over an extended period of time, including recurring episodes of a single underlying condition;
  - Requires periodic visits to a health care provider; and
  - May cause episodic rather than a continuing period of incapacity, including asthma, diabetes, and epilepsy
- Permanent/Long-term: A period of incapacity which is permanent or long-term due to a condition for which treatment may not be effective. The employee or family member must be under the continuing supervision of, but need not be receiving active treatment by, a health care provider, including Alzheimer's, a severe stroke, or the terminal stages of a disease; or
- Multiple treatments: Any period of absence to receive multiple treatments, including any period of recovery from the treatments.
- Substance abuse may be a serious health condition if the treatment meets other requirements in this definition.

HEALTHCARE PROVIDERS

Healthcare provider is defined in RCW 50A.05.010 and WAC 192-500-090 and means:

- A physician or an osteopathic physician who is licensed to practice medicine or surgery, as appropriate, by the state in which the physician practices;
- Nurse practitioners, nurse-midwives, midwives, clinical social workers, physician assistants, podiatrists, dentists, clinical psychologists, optometrists, and physical therapists licensed to practice under state law and who are performing within the scope of their practice as defined under state law by the state in which they practice;
- A health care provider listed above who practices in a country other than the United States, who is authorized to practice in accordance with the law of that country, and who is performing within the scope of the health care provider's practice as defined under such law; or
- Any other provider permitted to certify the existence of a serious health condition under the federal FMLA.

Note: 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 such information required to make a determination that the person is eligible to take the leave, or as otherwise 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 (excluding the medical history of the family member whose condition necessitates this leave) , 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.

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Washington Paid Family And Medical Leave Certification For Care Of Family Member (Form WA PFML-4)

PART A: MEDICAL FACTS

1. Diagnosis _____ Primary ICD Code *(optional)* _____

   Approximate date condition commenced: _____ Probable duration of condition: _____

   Was the patient admitted for an overnight stay in a hospital, hospice, or residential medical care facility? ☐ Yes ☐ No

   If so, dates of admission: _____

   _____

   Date(s) you treated the patient for condition: _____

   _____

   Will the patient need to have treatment visits at least twice per year due to the condition? ☐ Yes ☐ No

   Was the patient referred to other health care provider(s) for evaluation or treatment (e.g., physical therapist)? ☐ Yes ☐ No

   If so, state the nature of such treatments and expected duration of treatment: _____

   _____

2. Is the medical condition pregnancy? ☐ Yes ☐ No If so, expected/actual delivery date: _____

3. Complications with the pregnancy or delivery? ☐ Yes ☐ No Please explain: _____

   _____

   _____

   _____

4. Describe other relevant medical facts, if any, related to the condition for which the patient needs care (such medical facts may include symptoms, diagnosis, or any regimen of continuing treatment such as the use of specialized equipment):

   _____

   _____

   _____

PART B: AMOUNT OF CARE NEEDED: When answering these questions, keep in mind that your patient's need for care by the employee seeking leave may include assistance with basic medical, hygienic, nutritional, safety or transportation needs, or the provision of physical or psychological care:

5. Will the patient be incapacitated for a single continuous period of time, including any time for treatment and recovery? ☐ Yes ☐ No

   Estimate the beginning and ending dates for the period of incapacity: _____

   During this time, will the patient need care? ☐ Yes ☐ No

   Explain the care needed by the patient and why such care is medically necessary: _____

   _____

   _____

6. Will the patient require follow-up treatments, including any time for recovery? ☐ Yes ☐ No

   Estimate treatment schedule, if any, including the dates of any scheduled appointments and the time required for each appointment, including any recovery period: _____

   _____

   _____

   Explain the care needed by the patient, and why such care is medically necessary: _____

   _____

   _____

7. Will the patient require care on an intermittent or reduced schedule basis, including any time for recovery? ☐ Yes ☐ No

   Estimate the hours the patient needs care on an intermittent basis, if any:

   _____ hour(s) per day; _____ days per week from _____ through _____

   Explain the care needed by the patient, and why such care is medically necessary: _____

   _____

   _____

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8. Will the condition cause episodic flare-ups periodically preventing the patient from participating in normal daily activities?

☐ Yes ☐ No

Based upon the patient's medical history and your knowledge of the medical condition, estimate the frequency of flare-ups and the duration of related incapacity that the patient may have over the next 6 months (e.g., 1 episode every 3 months lasting 1-2 days):

Frequency: _____ times per _____ week(s) _____ month(s)

Duration: _____ hours or ____ day(s) per episode

Does the patient need care during these flare-ups? ☐ Yes ☐ No

Explain the care needed by the patient, and why such care is medically necessary _____

_____

_____

ADDITIONAL INFORMATION: IDENTIFY QUESTION NUMBER WITH YOUR ADDITIONAL ANSWER.

Health Care Provider's Name		Date	
Address	City	State	ZIP
Phone No.	Fax No.		
Specialty/Type of Practice		License No.	

I declare under penalty of perjury that the information provided in this form is true and correct, that the patient's condition meets the definition of "serious health condition" [RCW 50A.05.010], and that I am a healthcare provider authorized to certify their condition [RCW 50A.05.010 ; WAC 192-500-090].

Signature of Health Care Provider	Date

Print