Certification of Health Care Provider for Employee's Pregnancy Disability

California Disability Leave Law ("PDL")

INSTRUCTIONS to EMPLOYEE: You are required to submit a timely, complete, and sufficient medical certification to support your request for PDL leave due to your pregnancy, childbirth, or related medical condition. Providing this completed form is required to obtain (or retain) the benefit of PDL protections for your leave. Failure to provide a complete and sufficient medical certification to your employer may result in a delay or denial of your leave request.

You should return this completed form as soon as practicable, but no later than _____20____. You may return the form in person, by mail, or by fax. The fax number is _____. You should include a fax cover sheet marked "CONFIDENTIAL" and address your fax to "ATTENTION: _____."

SECTION I – To be completed by EMPLOYER

Employee's name: _____
Name and contact information of University's representative:
_____
Employee's job title: _____
Employee's regular work schedule: _____
Check if job description is attached: _____

SECTION II – To be completed by HEALTH CARE PROVIDER

INSTRUCTIONS to the HEALTH CARE PROVIDER: Your patient (our employee) has requested leave under the PDL due to a health condition related to her pregnancy or childbirth. Please answer, fully and completely, all applicable parts. Your answers should be based upon your medical knowledge, experience, and examination of the employee. Be sure to sign and date the form on page 2.

NOTE: DO NOT DISCLOSE ANY UNDERLYING DIAGNOSES WITHOUT THE EMPLOYEE'S CONSENT.

Provider's name and business address: _____
_____
Type of practice: _____
Telephone: (_____)_____ Fax:(_____)_____

1. Approximate date the employee became disabled by pregnancy, childbirth or related medical condition:
_____
Probable duration of period(s) of disability:_____
_____
_____

2. Use the information provided by the employer in Section I to answer these questions. If no job description is provided, the employer fails to provide a job description, answer these questions based upon the employee's own description of her job functions.

Is the employee <u>unable</u> to perform work of any kind without undue risk to herself, to others, or the successful completion of her pregnancy? ____ No ____ Yes
If no, is the employee <u>unable</u> to perform one or more of the essential functions of her position without undue risk to herself, to others, or the successful completion of her pregnancy? ____ No ____ Yes

3. Is it medically advisable that the employee be temporarily transferred to another position due to a health condition related to her pregnancy or childbirth? ____ No _____ Yes
If yes, what is the date the transfer became/will become medically advisable? _____
What is the probable duration of the period(s) of need for a transfer? _____
_____

4. Does the employee need an accommodation (other than a transfer) to be able to perform the functions of her position without undue risk to herself, others, or the successful completion of her pregnancy?
_____ No _____ Yes
Please describe your suggested accommodation(s): _____
_____
_____
_____
_____

ADDITIONAL INFORMATION:
_____
_____
_____
_____
_____
_____
_____
_____
_____

_____ _____
Signature of Health Care Provider **Date**