CERTIFICATION OF HEALTH CARE PROVIDER

for Pregnancy Disability Leave, Transfer and/or Reasonable Accommodation

Employee Name: _____

Please certify that, because of this patient's pregnancy, childbirth, or a related medical condition (including, but not limited to, recovery from pregnancy, childbirth, loss or end of pregnancy, or post-partum depression), this patient needs (check all appropriate category boxes):

☐ TIME OFF FOR MEDICAL APPOINTMENTS

When: _____ Duration: _____

☐ DISABILITY LEAVE *(Because of a patient's pregnancy, childbirth or a related medical condition, patient cannot perform one or more of the essential functions of patient's job or cannot perform any of these functions without undue risk to self, to successful completion of the pregnancy, or to other persons)*

Beginning (Estimate): _____ Ending (Estimate): _____

☐ INTERMITTENT LEAVE

Specify the intermittent leave schedule: _____

Beginning (Estimate): _____ Ending (Estimate): _____

☐ REDUCED WORK SCHEDULE

Specify the reduced work schedule: _____

Beginning (Estimate): _____ Ending (Estimate): _____

☐ TRANSFER/BE ASSIGNED TO A LESS STRENUOUS OR HAZARDOUS POSITION OR DUTIES

Specify the medically advisable position/duties: _____

Beginning (Estimate): _____ Ending (Estimate): _____

☐ REASONABLE ACCOMMODATION(S)

Specify (can include, but is not limited to, modifying lifting requirements, providing more frequent breaks, or providing a stool or chair): _____

Beginning (Estimate): _____ Ending (Estimate): _____

Printed Name of Health Care Provider: _____

_____

MEDICAL HEALTH CARE SPECIALTY LICENSE NUMBER

_____

SIGNATURE OF HEALTH CARE PROVIDER **DATE**

Authority Cited: Government Code sections 12935(a) and 12945
Reference: Government Code sections 12940 and 12945; FMLA, 29 U.S.C. § 2601, et seq.; FMLA regulations, 29 C.F.R. § 825