

**CERTIFICATION OF HEALTH CARE PROVIDER
FOR EMPLOYEE'S PREGNANCY DISABILITY
California Pregnancy Disability Leave Law (PDLL)**

PURPOSE of FORM: The below-named employee has requested a leave of absence due to a disability resulting from her pregnancy, childbirth, or related medical condition which may qualify as a protected leave under PDLL. This medical certification form will provide the University with information needed to determine if the employee's requested leave is for a qualifying reason under PDLL. Section II must be fully completed by the health care provider.

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

This form should be completed and returned within 15 calendar days. If you cannot return the completed form within the stated deadline, please contact _____ with the reasons for the delay and the date when the certification will be provided.

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 THE UNIVERSITY

EMPLOYEE'S NAME

EMPLOYEE'S JOB TITLE

EMPLOYEE'S REGULAR WORK SCHEDULE

NAME OF UNIVERSITY REPRESENTATIVE

UNIVERSITY REPRESENTATIVE MAILING ADDRESS

TELEPHONE

FAX

E-MAIL

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Check if job description listing essential functions 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 PDLL due to a disability resulting from her pregnancy, childbirth, or related medical condition. 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

BUSINESS ADDRESS

TELEPHONE

FAX

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

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

(a) Is the employee unable to perform work of any kind without undue risk to herself, others, or the successful completion of her pregnancy?	<input type="checkbox"/> Yes <input type="checkbox"/> No
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(b) If the employee is able to perform one or more of the essential functions of her position without undue risk to herself, others, or the successful completion of her pregnancy, please answer questions (i) and (ii) below.

(i) Is it medically advisable that the employee be temporarily transferred to another position due to a health condition related to her pregnancy or childbirth?	<input type="checkbox"/> Yes <input type="checkbox"/> No
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If yes, what is the date the transfer became/will become medically advisable?	____ ____ ____	
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What is the probable duration of the period(s) of need for a transfer?	From ____ ____ ____	To ____ ____ ____
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(ii) Is it medically advisable for the employee to take leave on an intermittent or reduced schedule basis?	<input type="checkbox"/> Yes <input type="checkbox"/> No
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If the employee needs reduced schedule leave, estimate the part-time or reduced work schedule the employee needs:

Employee should work no more than:

_____ Hour(s) per day _____ Days per week From _____|_____|_____ To _____|_____|_____

If the employee needs intermittent leave, estimate the frequency of need for intermittent leave and the duration of incapacity (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

SIGNATURE

SIGNATURE OF HEALTH CARE PROVIDER

DATE