



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): _____

Health Care Provider Name (print): _____

Medical Health Care Specialty: _____ **License Number:** _____

HEALTH CARE PROVIDER SIGNATURE _____ DATE _____