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): ____________________________

Authority Cited: Government Code sections 12935, subd. (a), and 12945
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