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 ___________________________

Authority Cited: Government Code sections 12935, subd. (a), and 12945
DFEH-E10P-ENG / July 2018