CERTIFICATION OF HEALTH CARE PROVIDER FOR PREGNANCY DISABILITY LEAVE, TRANSFER AND/OR REASONABLE ACCOMMODATION

Employee's 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.
Specify when and for what duration:
_____
_____

☐ A disability leave. [Because of a patient's pregnancy, childbirth or a related medical condition, she cannot perform one or more of the essential functions of her job or cannot perform any of these functions without undue risk to herself, to her pregnancy's successful completion, or to other persons.]
Beginning (Estimate):_____
Ending (Estimate):_____

☐ Intermittent leave. Specify medically advisable intermittent leave schedule:
_____
_____
Beginning (Estimate): _____
Ending (Estimate): _____

☐ Reduced work schedule. [Specify medically advisable reduced work schedule.]
_____
_____
Beginning (Estimate): _____
Ending (Estimate): _____

☐ Transfer to a less strenuous or hazardous position or to be assigned to less strenuous or hazardous duties [specify what would be a medically advisable position/duties].
_____
_____
Beginning (Estimate): _____
Ending (Estimate): _____

☐ Reasonable accommodation(s). [Specify medically advisable needed accommodation(s). These could include, but are not limited to, modifying lifting requirements, or providing more frequent breaks, or providing a stool or chair.]
_____

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

Name, license number and medical/health care specialty [printed] of health care provider.
_____
_____
_____

Signature of health care provider:
_____
Date:
_____

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

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