

# 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): \_\_\_\_\_

**Printed Name of Health Care Provider:** \_\_\_\_\_

\_\_\_\_\_  
MEDICAL HEALTH CARE SPECIALTY

\_\_\_\_\_  
LICENSE NUMBER

\_\_\_\_\_  
SIGNATURE OF HEALTH CARE PROVIDER

\_\_\_\_\_  
DATE