# CERTIFICATION OF HEALTH CARE PROVIDER PREGNANCY DISABILITY LEAVE AND/OR FAMILY AND MEDICAL LEAVE ACT

**SECTION I: For Completion by Employer - Instructions to Employer**

The Pregnancy Disability Leave Law ("PDL") and the Family and Medical Leave Act ("FMLA") provide that an employer may require an employee requesting Pregnancy Disability Leave and/or FMLA leave because of a need for leave due to a serious health condition to submit a health care provider certification issued by the employee's health care provider. Please complete **Section** I before giving this form to your employee.

Employer's name:_____

Employer contact:_____

Employer contact telephone number:_____

Employee's job title:_____

Employee's regular work schedule:_____

Employee's essential job functions: ☐ attached is the job description and/or list of essential job functions.

**SECTION II: For Completion by Employee - Instructions to Employee**

Please complete Section II before giving this form to your health care provider. The Pregnancy Disability Leave Law and the FMLA permit an employer to require that you submit a timely, complete, and sufficient health care provider certification to support a request for Pregnancy Disability Leave and/or FMLA leave due to your being disabled due to pregnancy, childbirth, or related medical conditions or your need for prenatal care. If requested by your employer, your response is required to obtain or retain the benefits of the Pregnancy Disability Leave Law and/or FMLA protections. Failure to provide a complete and sufficient health care provider certification may result in a denial or delay of your Pregnancy Disability Leave and/or FMLA request, or non-designation of your leave as Pregnancy Disability Leave and/or FMLA leave. You have 15 calendar days to return this form.

Employee name:_____
[First] [Middle] [Last]

**SECTION III: For Completion by Health Care Provider - Instructions to Health Care Provider**

The employee identified in Section I has requested leave under the Pregnancy Disability Leave Law and/or the FMLA for a disability related to pregnancy, childbirth, or related medical conditions or for prenatal care. Please fully answer all of the questions below. Several questions seek a response as to the frequency or duration of a condition, treatment, etc. Your answer should be your best estimate based upon your medical knowledge, experience, and examination of the patient. Be as specific as you can; terms such as "lifetime," "unknown," or "indeterminate" may not be sufficient to determine Pregnancy Disability Leave and/or FMLA coverage. Limit your responses to the condition for which the employee is seeking leave. Do not provide information about genetic tests, genetic services, or the manifestation of disease or disorder in the employee's family members. Finally, please be sure to sign the form on the last page.

1. Approximate date condition or need for treatment commenced [Note: The Health Care Provider is not to disclose the underlying diagnosis without the consent of the patient]:_____
   _____

2. Probable duration of medical condition or need for treatment_____

3. Is the employee, because of her pregnancy (which includes pregnancy, childbirth, or related medical conditions), unable to perform work at all or is unable to perform any one or more of the essential functions of her position without undue risk to herself, the successful completion of her pregnancy, or to other persons? ☐ Yes ☐ No

4. Use the information provided by the employer in Section I to answer this question. If the employer fails to provide a list of the employee's essential functions or a job description, answer these questions based upon the employee's own description of his and/or her job functions.

   a. Is the employee unable to perform work of any kind? ☐ Yes ☐ No

   b. If able to perform some work, is the employee unable to perform any one or more of the essential functions of the employee's position without undue risk to herself, the successful completion of her pregnancy, or to other persons? ☐ Yes ☐ No

   If so, identify the job functions the employee is unable to perform:

   _____

   _____

   _____

5. Will the employee be incapacitated for a single continuous period of time due to her medical condition, including any time for treatment and recovery? ☐ Yes ☐No

If so, estimate the beginning and ending dates for the period of incapacity:

_____

6. Will the employee (1) need intermittent leave to attend treatment appointments or prenatal care or (2) need to work part-time or on a reduced schedule because of the employee's medical condition? ☐ Yes ☐ No

    a. If so, are the treatments or the reduced number of hours of work medically advisable? ☐ Yes ☐ No

    b. Estimate the number of treatments if any, including the treatment schedule and dates of any scheduled appointments and the time required for each appointment, including any recovery:

_____

_____

_____

    c. Estimate the part-time or reduced work schedule the employee needs, if any:_____ hour(s) per day, _____ days per week from _____ through_____.

7. Will the condition cause episodic flare-ups periodically preventing the patient from participating in normal daily activities? ☐ Yes ☐ No

    Is it medically necessary for the employee to be absent from work to provide care during the flare-ups? ☐ Yes ☐ No

Based upon the patient's medical history and your knowledge of the medical condition, estimate the frequency of flare-ups and the duration of related incapacity that the patient may have over the next 6 months (e.g., 1 episode every 3 months lasting 1-2 days):

Frequency: _____ time(s) per _____ week(s) or _____ month(s)

Duration: _____ hour(s) per day _____ day(s) per episode

_____ _____

Type of Practice/Specialty Employee's Signature

Address

Date

City, State and Zip code

Telephone number

Fax Number

Signature of Health Care Provider

Date

Attachments:
Essential Functions of Position