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.