Stanislaus County
CEO- Risk Management Division
1010 10th Street Suite 5900, Modesto, CA 95354
Phn 209-525-5710 Fax 209-525-5779

Medical Certification of Employee
Pregnancy Related Disability
Leave, Transfer and / or Reasonable Accommodation

EMPLOYEE: The PDL/FMLA permits an employer to require that you submit a timely, complete and sufficient certification to support a request for PDL/FMLA leave due to a qualifying pregnancy related disability (including, but not limited to, doctor-ordered bed rest, severe morning sickness, prenatal or postnatal care, gestational diabetes, pregnancy-induced hypertension, preeclampsia, post -partum depression, lactation-related medical conditions, or recovery from loss or end of pregnancy). Employees must give department **30 days advance notice** or as much time as practicable and must **make a reasonable effort to schedule leave so as not to disrupt unduly the employer's operations.**

Employee: _____ Employee ID #: _____

Employee Job Title:_____ Department: _____

Expected Date of Delivery: _____ Pregnancy Disability Leave to Begin: _____

Bonding (CFRA) may be available when the period of actual disability due to pregnancy. childbirth and recovery or related medical conditions ends

Requested Bonding Leave to Begin: _____ Requested Return to Work Date: _____

TO BE COMPLETED BY HEALTH CARE PROVIDER

HEALTH CARE PROVIDER INSTRUCTIONS: Your patient has requested leave under the PDL/FMLA/CFRA. Your help is needed to determine if leave qualifies under PDL/FMLA/CFRA and to allow consideration of the employee's ability to work in a modified duty capacity. 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. Please answer fully and completely; terms such as "unknown," or "indeterminate" are not sufficient to determine PDL/FMLA/CFRA coverage Please be sure to sign the form on the last page.

1) Will employee require time off for medical appointments? ☐Yes☐ No

	Per Week		Per Month		Hours
Number of anticipated doctor visits	_____	or	_____	Number of hours per visits	_____

2) Is it medically advisable for the employee to have work restrictions (e.g. no lifting in excess of ____ lbs., no physical altercations, must be provided with a stool or chair, etc.)
☐Yes☐ No If yes identify any advisable restrictions below. Effective date: _____

Restrictions: _____

_____

3) Is it medically advisable for the employee to transfer to a less strenuous or hazardous position or to be assigned to less strenuous or hazardous duties?
☐Yes☐ No If yes identify any advisable restrictions below. Effective date: _____

Restrictions: _____

_____

4) Is it medically advisable for the employee to work a reduced schedule?
☐Yes☐ No If the employee needs a reduced schedule, estimate the part-time or reduced work schedule the employee needs:
Employee should work no more than: _____ Hour(s) per day _____ Days per week

Beginning Date: _____ Ending Date: _____

5) Is it medically advisable for the employee to take leave on an intermittent basis for periods of incapacity or medical treatment?
☐Yes☐ No If so estimate the frequency of the need for intermittent leave and the duration of incapacity to perform work duties:
Number of anticipated flare-ups _____ per ☐ week or ☐ month

Duration of flare-ups _____ per ☐ hours or ☐ days

6) Is employee unable to perform work of any kind without undue risk to herself, others or the successful completion of her pregnancy?
☐Yes☐ No Effective Date: _____ Ending Date (Estimate): _____

7) If no, is the employee <u>unable</u> to perform one or more of the essential functions of her position without undue risk to herself, to others, or the successful completion of her pregnancy?
☐Yes☐ No Effective Date: _____ Ending Date (Estimate): _____
Please specify specific essential functions that employee may not perform within the beginning and ending date _____
_____

Treating provider's name:	License #:	Phone:	Fax:
Business address:			
_____ Signature of Provider	_____ Date	_____ Medical Specialty	

I certify that I am the physician providing care for the patient identified in this document and that the statements made by me are true and correct to the best of my knowledge.

Reference: Government Code sections 12935, subd. (a), 12940, 12945; FMLA, 29 U.S.C. §2601, et seq. and FMLA regulations 29 C.F.R §825

The Genetic Information Nondiscrimination Act of 2008 (GINA) prohibits employers and other entities covered by GINA Title II from requesting or requiring genetic information of an individual or family member of the individual, except as specifically allowed by this law. To comply with this law, we are asking that you not provide any genetic information when responding to this request for medical information. "Genetic Information" as defined by GINA includes an individual's family medical history, the results of an individual's or family member's genetic tests, the fact that an individual or an individual's family member sought or received genetic services, and genetic information of a fetus carried by an individual or an individual's family member or an embryo lawfully held by an individual or family member receiving assistive reproductive services.