SJSU | PEOPLE AND CULTURE

CERTIFICATION OF HEALTH CARE PROVIDER FOR EMPLOYEE'S PREGNANCY DISABILITY

Purpose of the Form

Under the California Fair Employment and Housing Act (FEHA), if you are disabled by pregnancy, childbirth or related medical conditions, you are eligible to take a pregnancy disability leave (PDL). San Jose State University requires that an employee submit a timely, complete, and sufficient medical certification to support a request for PDL. You must return this completed form within 15 calendar days of your request. Failure to provide a complete and sufficient medical certification may result in a delay or denial of your PDL request.

Employees Instructions:

Please complete Section I before giving this form to your medical provider. Section II must be fully completed by the health care provider. For events which are unforeseeable, we need you to notify us as soon as you learn of the need for the leave.

SECTION I. FOR COMPLETION BY THE EMPLOYEE		
Employee Name:	Employee ID:	Home Phone:
Current Mailing Address:		
Department/College Name:		Campus Phone:
I authorize my health care provider to complete this form and provide information requested by San Jose State University. **NOTE:** The information sought on this form pertains only to the condition for which the employee is requesting leave from work.		
Employee Signature:		Date:

Health Care Provider Instructions:

Your patient (our employee) has requested leave under the PDL due to a health condition related to her pregnancy or childbirth. Please answer, fully and completely, all applicable parts. Your answers should be based upon your medical knowledge, experience, and examination of the employee. Be sure to sign and date the form on page 2.

SECTION II. FOR COMPLETION BY THE HEALTH CARE PROVIDER

1. What is the employees' estimated delivery date? ☐

2. Will the employee be incapacitated for a single continuous period of time due to his/her medical condition, including any time for treatment and recovery?

   ☐ Yes ☐ No

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

   Beginning: ☐ Through ☐ Anticipated return to work date: ☐

4. Does the employee need an accommodation (other than a transfer) to be able to perform the functions of her position without undue risk to herself, others, or the successful completion of her pregnancy? (This could include, but are not limited to, modifying lifting requirements, or providing more frequent breaks, or providing a stool or chair)

☐ Yes ☐ No

If Yes, please describe your suggested accommodation(s):

NEED FOR A TRANSFER

5. Is it medically advisable that the employee be temporarily transferred to a less strenuous or hazardous position or be assigned to less strenuous or hazardous duties due to a health condition related to her pregnancy or childbirth?

☐ Yes ☐ No

6. Please specify what would be a medically advisable position/duties.

SECTION III. HEALTH CARE PROVIDER INFORMATION	
Name of Health Care Provider:	Specialty:
Address:	Phone Number:
State License Number:	Licensed to practice in the state(s) of:
Signature:	Date: