Contra Costa County

Certification of Health Care Provider for Pregnancy Disability Leave, Transfer And/Or Reasonable Accommodation

Employee's Name: _____ EE#: _____

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 pregnancy 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 medically advisable intermittent leave schedule:

_____

_____

Beginning (Estimate): _____

Ending (Estimate): _____

☐ Reduced work schedule.
[Specify medically advisable reduced work schedule.]

_____

_____

Beginning (Estimate): _____

Ending (Estimate): _____

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☐ 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.

_____
Name

_____
License Number

_____
Medical/Health Care Specialty

Signature of health care provider:

_____ _____
Signature of Health Care Provider Date