Sacramento Employment and Training Agency

CERTIFICATION OF HEALTH CARE PROVIDER
FOR EMPLOYEE'S PREGNANCY DISABILITY
California Pregnancy Disability Leave (PDL)

PURPOSE of FORM: The below-named employee has requested a leave of absence due to a disability resulting from her pregnancy, childbirth, or related medical condition which may qualify as a protected leave under PDL. This medical certification form will provide SETA with information needed to determine if the employee's requested leave is for a qualifying reason under PDL. Section II must be fully completed by the health careprovider.

INSTRUCTIONS to EMPLOYEE: You are required to submit a timely, complete, and sufficient medical certification to support your request for pregnancy disability leave due to your pregnancy, childbirth, or related medical condition. Providing this completed form is required to obtain (or retain) the benefit of PDL protections for your leave. Failure to provide a complete and sufficient medical certification to SETA may result in a delay or denial of your leave request.

This form should be completed and returned within 15 calendar days. If you cannot return the completed form within the stated deadline, please contact **Deanna Dykes** with the reasons for the delay and the date when the certification will be provided.

You may return the form in person, by mail, or by fax. The fax number is 916-588-9176.

You should include a fax cover sheet marked "CONFIDENTIAL" and address your fax to:

"ATTENTION: Deanna Dykes."

SECTION I – To be completed by SETA/EMPLOYEE

EMPLOYEE'S NAME	EMPLOYEE'S JOB TITLE

EMPLOYEE'S REGULAR WORK SCHEDULE

NAME OF SETA REPRESENTATIVE	SETA REPRESENTATIVE MAILING ADDRESS
Deanna Dykes	925 Del Paso Blvd, Suite 100, Sacramento, CA 95815

TELEPHONE	FAX	E-MAIL
916-263-3906	916-588-9176	deanna.dykes@seta.net

SECTION II – To be completed by HEALTH CARE PROVIDER

INSTRUCTIONS to the HEALTH CARE PROVIDER: Your patient (our employee) has requested leave under PDL due to a disability resulting from her pregnancy, childbirth, or related medical condition. 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.

THE GENETIC INFORMATION NONDISCRIMINATION ACT OF 2008 (GINA): 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.

NOTE: DO NOT DISCLOSE ANY UNDERLYING DIAGNOSES WITHOUT THE EMPLOYEE'S CONSENT.

PROVIDER'S NAME

BUSINESS ADDRESS

TELEPHONE	FAX

1. Approximate date the employee became or will become disabled by pregnancy, childbirth or related medical condition:		
Probable duration of the period(s) of disability:	From	To

2. Use the information provided by SETA in Section I to answer these questions. If no job description is provided, answer these questions based upon the employee's own description of her job functions.

(a) Is the employee unable to perform work of any kind without undue risk to herself, others, or the successful completion of her pregnancy?	☐ Yes ☐ No

(b) If the employee is able to perform one or more of the essential functions of her position without undue risk to herself, others, or the successful completion of her pregnancy, please answer questions (i) and (ii) below.

(i) Is it medically advisable that the employee be temporarily transferred to another position due to a health condition related to her pregnancy or childbirth?		☐ Yes ☐ No
If yes, what is the date the transfer became/will become medically advisable?		
What is the probable duration of the period(s) of need for a transfer?	From	To
(ii) Is it medically advisable for the employee to take leave on an intermittent or reduced schedule basis?		☐ Yes ☐ No

If the employee needs reduced schedule leave, estimate the part-time or reduced work schedule the employee needs:

Employee should work no more than:

_____ Hour(s) per day _____Days per week From_____ To _____

If the employee needs intermittent leave, estimate the frequency of need for intermittent leave and the duration of incapacity (e.g. 1 episode every 3 months lasting 1-2 days).

Frequency:_____Times per ☐ week(s) ☐ month(s) Duration:____ ☐ Hours or _ ☐ Day(s) per episode

SIGNATURE

SIGNATURE OF HEALTH CARE PROVIDER	DATE