**Family and Medical Leave**

**Health Care Provider Certification for Maternity-related Disability and Parental Leave**

**PART 1 - Employee Information: To Be Completed by Employee**

<table>
<thead>
<tr>
<th>Employee name:</th>
<th>EID:</th>
<th>Employee phone:</th>
<th>Employee email:</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Department:</th>
<th>Supervisor’s name:</th>
<th>Supervisor’s email:</th>
</tr>
</thead>
</table>

- I am requesting continuous time off work □ No □ Yes
- I am requesting a reduced work schedule as follows □ No □ Yes
  - From (date) / / to (date) / / hours/day for days/week until (date) / /
- I am requesting an intermittent work schedule □ No □ Yes
- If yes, describe requested schedule (please print):

**Employee Signature:**

___________________________________________________________   Date: / /

**PART 2 – Medical Facts: To Be Completed by Health Care Provider**

Our employee is requesting time off from work or a modified work schedule under the FMLA as the birth mother of a newborn child. Please provide the information requested below.

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.

### For Pregnancy-Related Incapacity

<table>
<thead>
<tr>
<th>Expected date of delivery for your patient:</th>
<th>Expected dates of your patient’s physical incapacity due to pregnancy and delivery (separate from parental leave)</th>
<th>From (date): / / to (date): / /</th>
</tr>
</thead>
</table>

**Health Care Provider Information** (please print or attach business card)

Name:   
Specialty:

Business Address:   
Phone:

**Health Care Provider Signature:**

___________________________________________________________   Date: / /