Medical Certification Form
Accommodations for Pregnancy, Childbirth, and Related Medical Conditions

Employee Name: _____ **Date:** _____

Please identify the employee's workplace limitation(s). A physical or mental condition, impediment, or problem, such as needing to rest, reduce risk, or alleviate pain. It may be modest, minor, or episodic. It also can be for maintaining the health of the employee or pregnancy (if applicable), such as obtaining healthcare or childbirth recovery. You are not required to identify the employee's symptoms or provide a diagnosis.

Is the identified workplace need(s) related to, affected by, or arising out of pregnancy, childbirth, or a related medical condition? Related medical conditions include pregnancy symptoms such as nausea and fatigue; conditions such as gestational diabetes and preeclampsia; complications of pregnancy and childbirth such as ectopic pregnancy; prenatal and postpartum mental health conditions; labor and delivery; termination of pregnancy; lactation and related conditions such as low milk supply and engorgement; (in)fertility; use of contraception; and changes in pregnancy-related hormone levels and menstruation. You can answer yes even if pregnancy, childbirth or a related medical condition is not the sole or primary cause of the limitation.

Please circle one: **YES** **NO**

Describe the adjustment(s) or change(s) at work that would address the limitation. You may, but are not required to, suggest a specific accommodation. You may state what the employee should or should not do.

What is the expected duration of the need for the adjustment(s) or change(s)?

Certifying Health Care Provider Information. Doctors, midwives, nurses, nurse practitioners, physical therapists, lactation consultants, doulas, occupational therapists, vocational rehabilitation specialists, therapists, industrial hygienists, licensed mental health professionals, psychologists, psychiatrists, and other health care providers may certify employees for pregnancy/childbirth/related accommodations.

Provider Name: _____

Practice Name and/or Specialty: _____

Provider Signature: _____ **Date:** _____