**PDL Medical Certification Form (CAA3001)**

To be completed by the employee’s health care provider:

1. Employee’s Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
2. Company: [Company Name]
3. Patient’s Name (if other than employee): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
4. Date employee disabled due to childbirth, pregnancy, or related condition: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

*(Note: The health care provider is not to disclose the underlying diagnosis without the consent of the patient.)*

1. Probable duration of disability: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
2. Delivery Date (estimate): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
3. a. Is the employee able to perform her regular work duties? Answer after reviewing the employer’s job description that includes the essential functions of the employee’s position, or if none provided, after discussing with the employee.

Yes  No

1. If the answer to “a” is no, please what functions of their job they are unable to perform.
2. Details: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
3. Please answer the following question only if the employee is asking for intermittent leave or a reduced work schedule:
   1. Is it medically necessary for the employee to be off work on an intermittent basis or to work less than the employee’s normal work schedule in order to deal with the disability?

Yes  No

* 1. If the answer to “a” is yes, please indicate the number hours the employee is able to work and/or intermittent leave schedule.

Estimate: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Printed Name & Signature of Health Care Provider Date

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_

Signature of Employee Date

**This form must be completed by the Health Care Provider**

**and returned to the Employer by the Employee**