LOMPOC UNIFIED SCHOOL DISTRICT
Human Resources
1301 North A Street, Post Office Box 8000
Lompoc, CA 93438-8000
(805) 742-3280 Fax (805) 737-1712

PHYSICIAN CERTIFICATION

***Employee*: Please have your treating healthcare provider review your job duties with you as he/she completes this form. Return the completed form to the Human Resources Department.**

Employee Name:_____ **Job Title:** _____

SECTION I – To be completed PRIOR to delivery.

A. The employee is to be absent for medical reasons **due to pregnancy** beginning_____

B. The employee's ☐ estimated or ☐ actual date of delivery is/was _____

C. The employee is to **remain off work** until re-evaluated on_____

Date of next office visit_____

SECTION II – To be completed AFTER delivery and PRIOR to return to work.

D. The employee is able to work a full, **regular schedule with no restrictions**, beginning_____

E. The employee is **able to return to work with restrictions** required by this condition

Beginning:_____through _____

Date of next office visit for this condition _____

Please check and describe the restrictions required by this health condition:

☐ Stand (# of hrs.)_____	☐ Concentrate	☐ Breathe
☐ Walk (# of hrs.)_____	☐ Multi-task	☐ See
☐ Sit (# of hrs.)_____	☐ Communicate	☐ Eat
☐ Lift (# of lbs.)_____	☐ Bend, twist, stoop	☐ Think
☐ Push/Pull force (# of lbs.)_____	☐ Perform manual tasks	☐ Speak
☐ Use of hands/fingers (repetitive motion)	☐ Reach with arms/hands	☐ Learn

Describe restrictions, note any duties listed on the job description which are not recommended:

_____

_____

_____

_____ _____ _____

Name of Treating Healthcare Provider **Signature of Treating Healthcare Provider** **Date**

_____ _____

Address **Phone**