PUYALLUP SCHOOL DISTRICT
A Tradition of Excellence
John A. Polm, Ed.D., Superintendent

Puyallup School District - Documentation of Pregnancy Disability Leave

To Be Completed By Health Care Provider:

Patient/Employee's Name: _____

Child's Birth Date: _____

Medically Required Disability Leave:

☐ Patient experienced a vaginal delivery. She may not work for **6 weeks** following the child's birth date.

☐ Patient experienced a cesarean delivery. She may not work for **8 weeks** following the child's birth date.

☐ Patient is experiencing medical complications. She may not work for _____ **weeks**, due to the following specific medical diagnosis:

Return to Work:

Based on the above diagnosis and required recovery period, I certify that this patient may return to work on _____*(date*). On this date the employee will:

☐ resume all regular work duties with no restrictions.

☐ return with the following restrictions (*please include the duration of each restriction)*:

Health Care Provider Information (*professional stamp may also be used)*:

Name (Print): _____ Phone: _____

Address: _____

Signature: _____ Date: _____

Please return completed form to Krista McBride in the Puyallup School District Human Resources Department:

Fax: 253-841-8650, Phone: 253-435-2833, Mail: PO Box 370 Puyallup, WA 98371