OXNARD SCHOOL DISTRICT

1051 South "A" Street • Oxnard, California 93030 • 805/385-1501 • www.oxnardsd.org

CERTIFICATION OF HEALTH CARE PROVIDER FOR EMPLOYEE'S PREGNANCY DISABILITY
CALIFORNIA PREGNANCY DISABILITY LEAVE LAW (PDLL)

PURPOSE of FORM: The below-name employee has requested a leave of absence due to a disability resulting from her pregnancy, childbirth, or related medical condition which may qualify as a projected leave under PDLL. This medical certification form will provide the Oxnard School District information needed to determine if the employee's requested leave is for a qualifying reason under PDLL. **Section II** must be fully completed by the health care provider.

IMPORTANT NOTE: *The California Genetic Information Nondiscrimination Act of 2011 (CalGINA) prohibits employers and other covered entities from requesting, or requiring, genetic information of an individual or family member of the individual except as specifically allowed by law. To comply with the Act, we are asking that you not provide any genetic information when responding to this request for medical information. "Genetic Information," as defined by CalGINA, includes information about the individual's or the individual's family member's genetic tests, information regarding the manifestation of a disease or disorder in a family member of the individual, and includes information from genetic services or participation in clinical research that includes genetic services by an individual or any family member of the individual. "Genetic Information" does not include information about an individual's sex or age.*

INSTRUCTIONS to EMPLOYEE: You are required to submit a timely, complete, and sufficient medical certification to support your request for pregnancy disability leave due to pregnancy, childbirth, or related medical condition. Providing this completed form is required to obtain (or retain) the benefit of PDLL protections for your leave. Failure to provide a complete and sufficient medical certification to the Oxnard School District may result in a delay or denial of your leave request.

This form should be completed and returned within 15 calendar days.
You may return the form in person, by mail, fax (805) 385-1522, and/or email at leaves@oxnardsd.org
You should include a fax cover sheet marked "CONFIDENTIAL" and address your fax to:
"ATTENTION: Human Resources Leaves "

Section I – To be completed by Employer	
Employee's Name First Middle Last	
Employee's Position	
Employee's Regular Work Schedule	
Employer's Contact Name Mayra Magana & Erica Mata	**Telephone(s)** (805) 385-1501 ext. 2049 (805) 385-1501 ext. 2053
Fax (805) 385-1522	**E-Mail** **leaves@oxnardsd.org**
Section II – To be completed by Health Care Provider	

INSTRUCTIONS to the HEALTH CARE PROVIDER: Your patient (our employee) has requested leave under the PDLL due to a disability resulting from her pregnancy, childbirth, or related medical condition. Please answer, fully and completely, all applicable parts. Your answers should be based your medical knowledge, experience, and examination of the employee. Be sure to sign and date the form on page 2.

NOTE: DO NOT DISCLOSE ANY UNDERLYING DIAGNOSES WITHOUT THE EMPLOYEE'S CONSENT.

_____

PROVIDER'S NAME

_____

BUSINESS ADDRESS

TELEPHONE	FAX

1. Approximate date the employee became or will become disabled by pregnancy, childbirth or related medical condition:		
Probable duration of the period(s) of disability:	From:	To:
2. Use the information provided by the employer in Section I to answer these questions. If no job description is provided, answer these questions based upon the employee's own description of her job functions.		
(a) Is the employee unable to perform work of any kind without undue risk to herself, others, or the successful completion of her pregnancy?		☐ Yes ☐ No
(b) If the employee is able to perform one or more of the essential functions of her position without undue risk to herself, other, or the successful completion of her pregnancy, please answer questions (i) and (ii) below.		
(i) Is it medically advisable that the employee be temporarily transferred to another position due to a health condition related to her pregnancy or childbirth?		☐ Yes ☐ No
If yes, what is the date the transfer became/will become medically advisable?		
What is the probable duration of the period(s) of the need for a transfer?	From:	To:
(ii) Is it medically advisable for the employee to take a leave on an intermittent or reduced schedule basis?		☐ Yes ☐ No

If the employee needs reduce schedule leave, estimate the part-time or reduce work schedule the employee needs: Employee should work no more than:

_____ Hour(s) per day _____ Days per week From _____ To _____

If the employee needs intermittent leave, estimate the frequency of need for intermittent leave and the duration of incapacity (e.g., 1 episode every 3 months lasting 1-2 days).

Frequency: _____ Times per ☐ weeks(s) ☐ month(s) Duration: _____, ☐ Hours or _____ ☐ Day(s) per episode

SIGNATURE	
SIGNATURE OF HEALTH CARE PROVIDER	DATE