Human Resources

DOCTOR'S VERIFICATION OF LEAVE (AFTER BIRTH/PLACEMENT OF CHILD)

This form must be signed by your attending physician before it is sent to the Human Resources Office. If you have any questions regarding Pregnancy Disability Leave, the Family and Medical Leave Act, the California Family Rights Act or your leave benefits per Education Code or Collective Bargaining Agreement, please contact Human Resources at (760) 246-8691 ext. 10242.

SECTION 1 – TO BE COMPLETED BY THE EMPLOYEE	
Employee Name:	Classification
Site/Department	Phone Number
Address	
Email Address:	Date of Request

Employee Signature: ____________________________ Date: ____________

SECTION 2 – TO BE COMPLETED BY THE HEALTH CARE PROVIDER/ADOPTION PLACEMENT

Legislation requires the District to provide pregnant employees with the same benefits that other disabled employees receive. In order to do so, we must determine the actual time span that the employee will be disabled. A person who is disabled is one who is unable to perform the essentials duties of their position, with or without reasonable accommodation.

____________________________ Delivered her child on or; Child Placement Date: ____________

Employee/Patient's Name

She will be totally unable to perform the duties of her position through ____________

She may return to work on: ____________

If applicable, She has the following restrictions when returning to work:

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These restrictions continue until: ____________

Agent/Physician's Name: ____________________ License #: ____________

Medical Office or Agency: ____________________________

Phone Number: ____________________ Fax Number: ____________

Agent/Physician Signature: ____________________ Date ____________