



Completing the FMLA or Leave of Absence Medical Certification PREGNANCY OR PRENATAL CARE

Instructions for Employee

- Notify your manager of your need for leave of absence (in accordance with your employer's FMLA and/or leave of absence policies).
- Ask your health care provider to complete the Medical Certification and provide it (fax number is below) to Principal Absence Management Center within 15 calendar days.
- Consider following up with your health care provider to confirm that the Medical Certification has been completed and faxed to Principal Absence Management Center. It is your responsibility to provide timely, complete and sufficient certification. (Note: You may need to furnish your health care provider with any necessary authorization in order for the health care provider to release a complete and sufficient certification to support the FMLA request.)
- Be aware that this certification only applies to the time you are out related to incapacity due to pregnancy or prenatal care. If you also have requested leave to bond with your child, your health care provider does not need to include those dates.

Principal Absence Management Center will notify you whether your leave has been approved or denied (via your preferred method of communication, email or postal mail) once we receive a complete and sufficient certification. Alternatively, we will notify you if additional information is required. Failure to provide a complete and sufficient medical certification may result in a denial of your FMLA request.

Instructions for Health Care Provider

Please answer fully and completely the four sections on the following pages and sign the form.

Step 1 — PATIENT'S CONDITION. Certify whether your patient is requesting leave for prenatal care, and/or related to her incapacity due to pregnancy (including childbirth). If the request is related to an incapacity, also include information sufficient to establish that she cannot perform the essential functions of her job as well as the nature of any other work restrictions, and the likely duration of such incapacity. Do not provide information related to genetic tests or services.

Step 2 — DUE DATE. Provide the estimated due date (date of delivery) or, if she already has delivered, the date of delivery.

Step 3 — DATES OF LEAVE. Provide the requested dates of leave. Note that this may include continuous time as well as occasional time off for appointments or episodes. If the pregnancy requires the patient to take any time off work in addition to regular prenatal appointments, **please provide your best estimate** of the frequency and duration of absences.

Step 4 — SIGNATURE. Sign the form and provide your type of practice/medical specialty.

Return the completed form via fax to Principal Absence Management Center at 1.877.309.0218 before the listed due date. If you do not complete all steps in full and return it before the due date, your patient's leave may be denied.

For purposes of California: 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.

The Genetic Information Nondiscrimination Act of 2008 (GINA) prohibits employers and other entities covered by GINA Title II from requesting or requiring genetic information of an individual or family member of the individual, except as specifically allowed by this law. To comply with this law, we are asking that you not provide any genetic information when responding to this request for medical information. "Genetic information," as defined by GINA, includes an individual's family medical history, the results of an individual's or family member's genetic tests, the fact that an individual or an individual's family member sought or received genetic services, and genetic information of a fetus carried by an individual or an individual's family member or an embryo lawfully held by an individual or family member receiving assistive reproductive services.

FMLA or Leave of Absence Medical Certification

Medical Certification PREGNANCY OR PRENATAL CARE

Employee/Patient Name: _____ Employer: _____
Leave Request #: _____ Due Date: _____
Request for leave due to: Employee's own serious health condition
Dates of leave (probable) requested by patient:
- Continuous leave, date range request: _____ to _____
- Intermittent leave, date range request: _____ to _____
- Reduced schedule leave, date range request: _____ to _____

STEP 1 – PATIENT'S CONDITION. Answer both sections A and B.

(A) Describe Appropriate Medical Facts*: Provide a statement or description of appropriate medical facts regarding the patient's pregnancy for which FMLA leave is requested (i.e., leave is medically necessary). The medical facts must be sufficient to support the need for leave. This may be related to the pregnancy, prenatal care, or for her own serious health condition following the birth of the child.

**Such medical facts may include information on symptoms, diagnosis, hospitalization, doctor visits, whether medication has been prescribed, and referrals for evaluation or treatments (physical therapy, for example), or any other regimen of continuing treatment, such as the use of specialized equipment (Not required in California).*

(B) If the leave is due to an incapacity, confirm employee cannot perform the essential functions of the job. *Your patient should provide you with a description of her job functions.*

Is the employee unable to perform any of her job functions due to the condition? ___No ___Yes

If so, identify the job functions the employee is unable to perform and the nature of the work restrictions and the duration of such inability:

STEP 2 – DUE DATE. Please provide the estimated or actual due date:

- **Estimated Due Date:** ___/___/___ (MM/DD/YYYY)
- OR
- **Actual Delivery Date:** ___/___/___ (MM/DD/YYYY) (If patient already delivered)

Please continue to the following page to provide information regarding dates of leave.

STEP 3 – DATES OF LEAVE.

Directly below, please provide all requested leave dates associated with your patient's pregnancy related to prenatal care or for incapacity due to her pregnancy.

- This could include both time before the birth of the child for prenatal care or if her condition makes her unable to work or for a serious health condition following the birth of the child.
- This should include any **continuous** leave as well as any occasional time off she will need (**intermittent or reduced schedule**). Please use the correct box below depending upon the leave type.
- Use your best estimate. **Answers of "unknown" or "indeterminate" may not be sufficient to determine FMLA coverage.**

- Continuous Leave:** *Is the patient unable to work for a single, continuous period of time?*
- Start date of incapacity ____ / ____ / ____ (DD/MM/YYYY)
 - Estimated end date of incapacity ____ / ____ / ____ (DD/MM/YYYY)
 - Will the employee require follow-up appointments? *If so, please indicate the frequency of incapacity below in section iii under "Intermittent Leave" as well as any past treatment dates in section v.*

Intermittent Leave:

Is the patient able to work but needs occasional time off related to her pregnancy?

- Start date for leave or initial appointment date
____ / ____ / ____ (DD/MM/YYYY)
- Probable end date for leave
____ / ____ / ____ (DD/MM/YYYY) or
- Prenatal or Postnatal appointments/treatments** - Will the patient need to miss work for appointments or treatments?
 - No
 - Yes – Estimate treatment schedule:
 - Frequency: Up to ____ times per ____ (week, month, or year)
Duration: Up to ____ (hours or days)
 - Please include the dates of any scheduled appointments and the time required for each appointment:

- Prenatal or Postnatal flare-ups/episodes** - Will the patient need to miss work for episodes of incapacity/flare-ups related to her pregnancy or childbirth?
 - No
 - Yes – Estimate of absences needed for episodes:
 - Frequency: May occur up to ____ times per ____ (week, month, or year)
Duration: May last up to ____ (hours or days)

- v. Dates you have already treated the patient for her pregnancy:

AND/OR

Reduced Schedule Leave:

Is the patient working on a FIXED part-time schedule or taking predictable regularly scheduled absences for her pregnancy?

Start Date of Leave:

____ / ____ / ____
(DD/MM/YYYY)

Probable End Date of Leave:

____ / ____ / ____
(DD/MM/YYYY)

Su	
M	
Tu	
W	
Th	
F	
Sa	

(Please indicate the hours the patient will need to miss each day)

STEP 4 – SIGNATURE. Health Care Provider Information:

Name: _____ Practice/Specialty and Credentials: _____
Street Address: _____ Fax Number: _____
City, State, ZIP Code _____ Signature: _____
Phone Number: _____ Date: _____

Phone: 877-734-3652 Fax: 877-309-0218

Principal Absence Management Center Email: LeaveCenter@principal.absencemgmt.com

To mail: Principal Absence Management Center, 455 N. Cityfront Plaza Drive, Chicago, IL 60611-5322

GINA prohibits employers from requesting genetic information. See instructions on first page.