Parish/School

Certification of Physician or Practitioner for Pregnancy Disability Leave

Employee's Name: _____

Date employee became or will become disabled due to pregnancy, childbirth, or related medical condition: _____

I anticipate that the above named employee will be disabled for:

_____ (estimated date of return to work)

I hereby certify that the employee named above is disabled because of pregnancy, childbirth or related medical conditions as of the date stated above and that the employee is unable to work at all or is unable to perform any one or more of the essential functions of her position, without undue risk to herself or to other persons.

_____ _____

Signature of Physician or Practitioner Date

Physician or Practitioner Information:

Name _____

Address _____

Telephone # _____