Paid Parental Certification for Health Care Provider

Instructions for Employee

- Please give this Certification for Health Care Provider form to your family member or their health care provider
- Failure to provide a complete and sufficient medical certification may result in the denial of your request
- You must return the completed Certification for Health Care Provider form (or a sufficient alternative) within sixty (60) calendar days of taking the leave

Instructions for Health Care Provider

- Answer, fully and completely, all applicable parts of the below form
- Do **NOT** provide information about genetic tests, genetic services, of the manifestation of disease or disorder in the employee's family members
- Please be sure to sign the form

Patient Name: Patient Date of Birth:	Employee's Name:

Medical Facts:

Estimated Date of Delivery: _____ ***(MM/DD/YYYY)***

Confirmed Date of Delivery (if known): _____ ***(MM/DD/YYYY)***

REQUIRED – Health Care Provider Contact & Signature:

Provider's Printed Name & Credentials:

Provider Address:

Provider Signature:

Provider Telephone #:

Date:

Provider Fax #:

Type of Practice/Specialty: