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PRENATAL LEAVE MEDICAL CERTIFICATION FORM (PFL-PMC)

INSTRUCTIONS FOR CLAIMANT:

Use this form to file for Prenatal Leave benefits with the DC Office of Paid Family Leave. This form is used to verify your pregnancy and eligibility for benefits. You must complete part 1 of the form. Your doctor or licensed health care provider must complete part 2.

PART 1 (To be completed by the claimant)

Last Name	First Name	Middle Name

Date of Birth (MM/DD/YYYY)
_____ /_____ /_____

PART 2 (To be completed by the licensed health care provider)

INSTRUCTIONS FOR HEALTH CARE PROVIDER:

Your patient is requesting Paid Family Leave benefits from the District of Columbia. The purpose of this form is to determine your patient's eligibility for benefits by verifying the diagnosis of your patient's pregnancy. Please complete sections A through D.

A. HEALTH CARE PROVIDER INFORMATION

All fields are required, except where noted

Provider Last Name	Provider First Name

Mailing Address — Street | City | State | Zip code

Telephone Number	Email Address

Type of Practice / Medical Specialty

State License Number	National Provider Identifier (Optional)

B. INFORMATION ABOUT YOUR PATIENT'S PREGNANCY

What was the date you first confirmed by examination the existence of your patient's pregnancy?

_____
(MM/DD/YYYY)

What was the date you first provided treatment for your patient's pregnancy, if any?

_____
(MM/DD/YYYY)

What is your patient's expected due date?

_____
(MM/DD/YYYY)

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C. AMOUNT OF LEAVE NEEDED

Check the box for each statement that is applicable to your patient's prenatal medical care.

☐ **Prenatal Check-Up Appointments:** Your patient was seen, or will be seen, on the following date(s) for pregnancy check-up appointments:

_____ (mm/dd/yyyy)

☐ **Specialist Appointments:** Your patient did or will require routine or specialty exams or treatments associated with the pregnancy on the following date(s):

_____ (mm/dd/yyyy)

☐ **Diagnostic Appointments:** Your patient attended diagnostic appointment(s) in order to provide medical information about the health or well-being of the embryo or fetus (e.g., amniocentesis, ultrasounds, or blood tests) on the following date(s):

_____ (mm/dd/yyyy)

☐ **Treatment for Pregnancy Complications:** Your patient is experiencing complications with the pregnancy that did or will require treatment on the following date(s):

_____ (mm/dd/yyyy)

☐ **Treatment for High-Risk Pregnancy:** Your patient's pregnancy is considered "high-risk" and did or will require specialist treatment or evaluation on the following date(s):

_____ (mm/dd/yyyy)

☐ **Bedrest:** Your patient is medically required to remain on bedrest during the following period: _____ (mm/dd/yyyy) to _____ (mm/dd/yyyy).

☐ **Physical Therapy:** Your patient did or will require physical therapy to treat symptoms of, or to relieve physical discomfort associated with, pregnancy on the following date(s):

_____ (mm/dd/yyyy)

☐ **None of the above.** None of the statements above describe your patient's pregnancy.

D. CERTIFICATION

Please provide any additional information about your patient's condition or their need for leave.

_____

_____

_____

☐ I certify that I am a licensed health care provider that is treating this patient and the information I have provided on this form is true and complete.

Signature: _____ Date: _____

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