**Section 1: Employee Information**

|  |  |  |  |
| --- | --- | --- | --- |
| Full Name: |  | | |
| Employee ID: |  | Department: |  |
| Job Title: |  | Date of Birth: |  |
| Contact Number: |  | Email Address: |  |

**Section 2: Verification Details**

|  |  |  |  |
| --- | --- | --- | --- |
| Healthcare Provider’s Name: |  | Healthcare Provider’s Contact Number: |  |
| Healthcare Provider’s Address: | Street Address: City, State, ZIP Code. | | |

**Section 3: Pregnancy Details**

|  |  |  |  |
| --- | --- | --- | --- |
| Expected Due Date: |  | Date Pregnancy Confirmed: |  |

**Section 4: Healthcare Provider’s Certification**

I hereby certify that the above-named employee is pregnant and the information provided is accurate to the best of my knowledge.

|  |  |  |  |
| --- | --- | --- | --- |
| Healthcare Provider’s Signature: | Signature | Date: | (DD/MM/YYYY) |
| Healthcare Provider’s Printed Name: |  | Medical License Number: |  |

**Section 5: Employee Authorization**

I authorize my healthcare provider to release the above information to my employer for the purpose of verifying my pregnancy and determining eligibility for any applicable benefits and accommodations.

|  |  |  |  |
| --- | --- | --- | --- |
| Employee’s Signature: | Signature | Date: |  |

**Section 6: For HR Department Use Only**

|  |  |  |  |
| --- | --- | --- | --- |
| Received By: |  | Date: | (DD/MM/YYYY) |
| Processed By: |  | Date: | (DD/MM/YYYY) |
| Approved By: |  | Date: | (DD/MM/YYYY) |

**Section 7: Comments**

**Additional Comments:**

|  |
| --- |
|  |
|  |
|  |
|  |

|  |  |  |  |
| --- | --- | --- | --- |
| **HR Signature:** | Signature | **Date:** | (DD/MM/YYYY) |