

# MEDICAL CERTIFICATION FORM



THE UNIVERSITY OF  
TENNESSEE  
KNOXVILLE

## Workplace Accommodations for Pregnancy, Childbirth, and Related Medical Conditions

**Employee Name:** \_\_\_\_\_

The University of Tennessee (University) employee named above has requested reasonable accommodation at the workplace based on pregnancy, childbirth, or a related medical condition. Under the Pregnant Workers Fairness Act (PWFA), a qualified employee or job applicant has a right to request reasonable accommodation if known limitations related to, affected by, or arising out of pregnancy, childbirth, or related medical conditions. You are being asked by the employee to provide documentation by fully completing all sections of this form. These questions will help 1) confirm the physical or mental condition, 2) confirm that the physical or mental condition is related to, affected by, or arising out of pregnancy, childbirth, or related medical conditions, and 3) identify what options may exist that would constitute an effective, reasonable accommodation.

The completed form may be returned to the employee or emailed to the Office of Equal Opportunity & Accessibility (EOA) (eoa@utk.edu)

### Please identify the employee's workplace limitation(s).

### Is the identified workplace limitation(s) related to, affected by, or arising out of pregnancy, childbirth, or a related medical condition?

Related medical conditions include pregnancy symptoms such as nausea and fatigue; conditions such as gestational diabetes and preeclampsia; complications of pregnancy and childbirth such as ectopic pregnancy; prenatal and postpartum mental health conditions; labor and delivery; termination of pregnancy; lactation and related medical conditions such as low milk supply and engorgement; (in)fertility; use of contraception; and changes in pregnancy-related hormone levels and menstruation. You can answer yes even if pregnancy, childbirth, or a related medical condition is not the sole or primary cause of the limitation.

**Please circle one: YES NO**

**Describe the adjustment(s) or change(s) at work that would address the limitation.**

You may, but are required to, suggest a specific accommodation. You may state what the employee should or should not do.

**What is the expected duration of the need for the adjustment(s) or change(s)?**

**Certifying Health Care Provider Information:**

Provider Name (printed): \_\_\_\_\_

Practice Name and/or Speciality: \_\_\_\_\_

Practice Phone and Fax Number: \_\_\_\_\_

\_\_\_\_\_  
Signature of the physician or care provider

\_\_\_\_\_  
Date