Certification of Health Care Provider for Maternity Leave

Please note: In accordance with MIT’s sick leave policy, medical documentation must be completed by a physician in order to qualify for paid sick leave.

**Employer name and Contact:** MIT Disabilities Services and Medical Leaves Office; Tel: (617)253-4572 or (617)324-0082, Email: hr-dsmlo@mit.edu, Confidential Fax: (617)253-1502

---

Employee name: __________________________________________

MIT ID: __________________________ Phone number: __________________________

---

**For Completion by the PHYSICIAN:**

Physician’s name and business address: __________________________________________

Telephone: (_____) __________________ Fax: (_____) __________________

---

1. Expected Delivery Date: __________________________

---

2. MIT provides up to 8 weeks of paid leave associated with disability and recovery from childbirth. Will this individual require the standard 8 weeks following delivery:

   ______ Yes    ______ No (if “No”, please explain and provide the anticipated duration of disability):

   ____________________________

---

3. If there are any other relevant medical facts related to the condition for which the employee seeks leave please provide detailed information and attach it to this form (such medical facts may include symptoms, diagnosis, or any regimen of continuing treatment such as the use of specialized equipment)

---

**Physician signature** __________________________ **Date** __________________________

---

**Employee signature** __________________________ **Date** __________________________