- Form to be completed by Health Care Provider and Returned to Employee
- Employee to return completed form to University Human Resources, 3810 Beardshear Hall or Fax # 515-294-1702

Iowa State University

Pregnancy Leave

Part I: For Completion by the EMPLOYEE

Name of Employee: ________________________________ University ID: ________________________

Supervisor's Name: ________________________________ Phone Number: ______________________

The time during which an employee is unable to work because of disability or illness caused or contributed to by pregnancy, miscarriage, abortion, childbirth, and recovery therefrom will be covered under the provisions of the university's medically-related disability leave program. Under Chapter 216.6 (2) (e) of the Iowa Code, when leave is not available, an employee who is disabled by the pregnancy will be granted up to eight (8) weeks of unpaid leave upon written verification by a health care provider that the employee is not able to reasonably perform the duties of employment.

______________________________________ ________________________

Signature of Employee Date

Part II: For Completion by the HEALTH CARE PROVIDER

Provider's name and business address: ____

Type of practice/ Medical specialty: ____

Telephone: (____) ______________________ Fax: (_____) ______________________________

Approximate date of delivery: _________________________

Description of reason(s) why employee is not able to reasonably perform the duties of employment:

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If you have questions, contact University Human Resources at 515-294-8917

Revised 11/18

Duration/dates of employee's inability to reasonably perform the duties of employment:

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_____________________________________ _____________________________________

Signature of Health Care Provider Date