UNIVERSITY of MARYLAND BALTIMORE

Human Resources
Pregnancy Accommodation Employee Request Form

The Pregnant Worker Fairness Act ("PWFA") requires the University of Maryland, Baltimore ("UMB") to provide reasonable workplace accommodations for employees whose ability to perform job duties are temporarily limited because of known physical or mental condition related to, affected by, or arising out of pregnancy, childbirth, or a related medical condition.

The purpose of this form is to assist UMB with facilitating the interactive process to determine whether a reasonable accommodation can be granted; and/or to confirm that a request that has been made or that an accommodation has been approved via other means.

Completed forms must be submitted to:
University of Maryland; Attn: Human Resources; ER/LR
620 West Lexington Street, 3rd Floor; Baltimore, MD 21201
Phone: 410-706-7302 | Fax: 410-706-0169 E-mail: leaveforms@umaryland.edu

Required Information	Information
Name:	
Position:	
Department:	
Phone:	
Supervisor's Name:	
Supervisor's Title:	
Employee Status:	☐ Faculty ☐ Staff

1. Describe the specific accommodation(s) you are requesting:

2. Please indicate the date the accommodation(s) will become necessary and the estimated length of the accommodation(s), if known:

3. Please provide a brief explanation of the physical or mental condition related to, affected by, or arising out of pregnancy, childbirth, or a related medical condition and the need for the requested accommodation(s):

Employee Signature _____ Date _____

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PWFA Medical Certification

Some accommodations do not require medical certification, therefore please only have your health care provider complete this section if requested by Human Resources.

1. Does the employee have a limited related to, affected by, or arising out of pregnancy, childbirth, or a related medical condition? Yes ☐ or No ☐
2. If the answer to question 1 is *Yes*, describe the physical or mental condition related to, affected by, or arising out of pregnancy, childbirth, or a related medical condition and the need for the reasonable accommodation.

   _____
   _____
   _____
   _____

3. Describe the accommodation(s) that would address the limitation and the estimated length of time the accommodation(s) will be necessary:

   _____
   _____
   _____
   _____

4. Date the accommodation(s) became or will become medically advisable:

   From _____ (mm/dd/yyyy) to _____ (mm/dd/yyyy)

5. List of other documentation attached to this form, if applicable:

_____
_____
_____
_____

Medical Provider Information	
Medical Provider Name:	
Phone Number:	
Fax Number:	

Medical Provider Signature	
Provider Signature:	
Date:	

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