

SDI Online Tutorial:

Physician/Practitioner and

Physician/Practitioner Representative

Registration, Online Access Information, and

Form Submission

SDI Online Overview for Physicians/Practitioners and Representatives

The way you access Employment Development Department (EDD) benefits and services has changed.

You will now complete a one-time registration for Benefit Programs Online, but will still file your Disability Insurance (DI) and Paid Family Leave (PFL) medical certifications using SDI Online.

Physicians/practitioners and Physician/practitioner representatives:

You may use SDI Online to:

- Complete medical certifications for Disability Insurance and Paid Family Leave benefits.
- Complete medical certifications for benefits on behalf of the physician/practitioners.
- Update contact information.
- Access electronic requests for additional medical information.

- A physician/practitioner may have an unlimited number of authorized representatives.
- A physician/practitioner representative may create an account after the physician/practitioner has added them as an authorized representative to their SDI Online account.
- An individual may be an authorized representative for an unlimited number of physicians/practitioners.

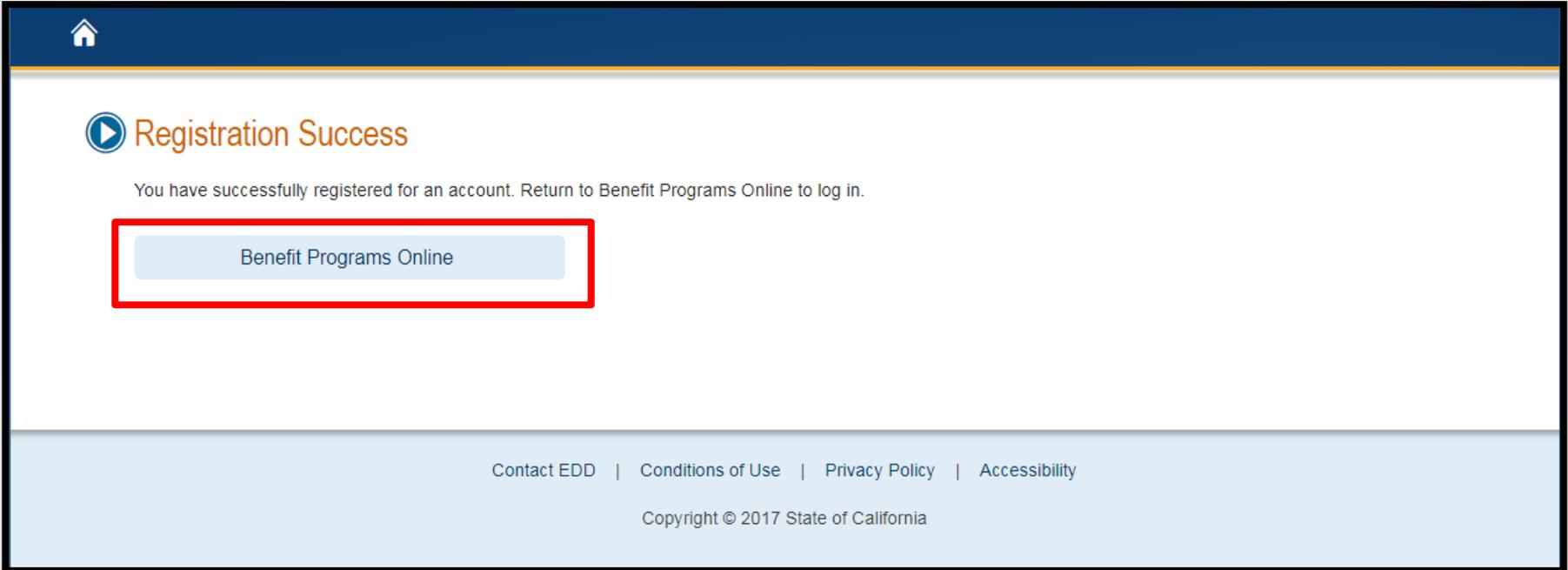
New Registration Benefit Programs Online

You must first complete a one-time registration in Benefit Programs Online to access SDI Online as a physician/practitioner or physician/practitioner representative.

To register for Benefit Programs Online, visit:
edd.ca.gov/BPO.

Watch our [Benefit Programs Online video](#) for registration instructions on a new account.

SDI Online Account Registration for Physician/Practitioners



Once you have completed your Benefit Programs Online registration, select the **Benefit Programs Online** button to complete your SDI Online registration process.



▶ Log in to Benefit Programs Online

[En español](#)

Email:

I'm not a robot



Log In

Don't have an account? [Register now.](#)

Benefit Programs Online gives you access to these EDD services:

- Unemployment or Pandemic Unemployment Assistance
- Disability
- Paid Family Leave
- Benefit overpayments

Enter the email address used to register, complete the security check, and select **Log In**.



▶ Password

To log in to Benefit Programs Online, you must verify your personal image and personal caption, and enter your password.

* Indicates required field.

Personal Image:



Personal Caption: IOU TEST

* Password:

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[Log In](#)

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Enter the password you created during the registration process and select **Log In**.

If you do not recognize your personal image and caption, review the email address entered on the log in screen to make sure it is correct. Call 1-800-480-3287 for further assistance.



Benefit Programs Online

UI OnlineSM

UI Online is a fast, convenient, and secure way for Unemployment Insurance (UI) customers to file a new claim or manage an existing claim.

Select UI Online to file a claim for UI benefits or to create or access your UI Online account.

To use UI Online Mobile, you must have already created a UI Online account.

UI Online

UI Online Mobile

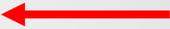
SDI Online

SDI Online is a fast, mobile-friendly, and secure way for claimants, physicians/practitioners, physician/practitioner representatives, employers, and voluntary plan administrators to file a new claim, manage a claim, or submit forms online.

Select SDI Online to file a claim for Disability Insurance or Paid Family Leave benefits or to create or access your SDI Online account.

SDI Online

Note: You will be logged out after 30 minutes on any page.



To log out of Benefit Programs Online from any page, select the **Log Out** link in the top right hand corner.

After you have logged in, select the **SDI Online** link to complete your registration for SDI Online.

SDI Online Registration

Select your account type.

Claimant

Select **Register as a Claimant** to:

- File a Disability Insurance (DI) or Paid Family Leave (PFL) claim.
- Access your claim information.
- View your benefit payment history.

You will need:

- Social Security number
- California driver license (CDL) or identification (ID) card

Note: If you do not have a CDL or ID, you will need to file DI by mail or file PFL by mail.

Claimant registration is available from Monday to Saturday 6 a.m. to 6 p.m. and Sunday 6 a.m. to 5:30 p.m.

Register as a Claimant

Employer

Select **Register as an Employer** if you represent an employer.

You will need:

- Employer Account Number (EAN)
- Employer ZIP Code (as filed with the EDD Tax Branch)
- Total Subject Wages from the most recent DE 9C

Register as an Employer

Physician/Practitioner

Select **Register as a Physician/Practitioner** to certify Disability Insurance (DI) or Paid Family Leave (PFL) claims for your patients.

You will need:

- Medical license information (as filed with the California Department of Consumer Affairs)
- California driver license (CDL) or identification (ID) card

Physician/practitioner registration is available from Monday to Saturday 4 a.m. to 12 midnight and Sunday 4 a.m. to 9 p.m.

Register as a Physician/Practitioner



Physician/Practitioner Representative

Select **Register as a Representative** if a physician/practitioner designated you as their representative to certify Disability Insurance (DI) or Paid Family Leave (PFL) claims for their patients through SDI Online.

Note: You must match the information entered by the physician/practitioner.

Register as a Representative

You will be directed to the **SDI Online Registration Options** page.

Select the link for **Physician/Practitioner Registration**.

Physician/Practitioner: Terms and Conditions

Terms and Conditions

Please read through the entire Terms and Conditions before proceeding. The information you provide may be used to verify your identity with federal and/or state agencies. If “I Do Not Agree” is selected, you will not be able to establish an online account.

These Terms and Conditions, which include the Conditions of Use and Privacy Statements, govern the use of and access to: (i) this website (www.edd.ca.gov/); and (ii) the information on or provided through this website.

If you establish an online account you are responsible for maintaining the confidentiality of your username and password, and you are responsible for all activities which you authorize under your username and password. You agree to: (i) immediately notify the Employment Development Department (EDD) of any unauthorized use of your username and password or any other breach of security; and (ii) log out from your account at the end of each session.

By registering for an online account, you agree to check your account regularly and frequently for messages from the EDD. Please note that e-mails will only be used to send notifications to log in to your account or when you request to reset your username or password. No confidential claim information will be sent via e-mail.

The information submitted by any party will be used by the Employment Development Department to carry out its responsibilities under the California Unemployment Insurance Code, which may include the sharing of the information with other entities as required by law.

These Terms and Conditions may change from time to time and it is your responsibility to check for updates. The last revision date for these Terms and Conditions is February 1, 2012.

I have read and understand all the above information and wish to continue with establishing an account in the State Disability Insurance (SDI) Online.

You must agree to the terms and conditions to continue. Select **I Agree**.

Physician/Practitioner: Account Verification Information

*Indicates Required Field

To register for a new SDI Online account, provide the following information.

Personal Information

Please enter your full legal name to register.

*First Name:

Middle Name: (If you have no middle name, leave blank.)

*Last Name:

Suffix: (If you have no suffix, leave blank.)

E-mail Address: smth.jones2020@edd.ca.gov

*State of Birth: (select)

*Last Four Digits of Social Security Number:

*CA Driver License or CA State ID Number:

*Re-Type CA Driver License or CA State ID Number:

Physician/Practitioner Information

*License Type: (select)

*Physician/Practitioner License Number:

NPI Number:

*License Expiration Date: (select)

Medical School Name:

Medical School Year Graduated:

Address and Phone Number

Please enter the address and phone number as provided to the Department of Consumer Affairs.

US International

*Address Line 1:

Address Line 2:

*City:

*State: CA

*ZIP Code:

*Phone Number: (no dashes or spaces) Ext:

Check box if the phone number is international

Complete the account verification information and select **Next**.

Mandatory fields are marked with a red asterisk (*).

When creating an SDI Online account, remember to:

- Enter the personal medical information as it appears in the registration with your medical board.
- Enter the mailing address the medical board has on file.

Note: You will be able to add treatment addresses once the account is created.

Physician/Practitioner: Personal Profile Information

*Indicates Required Field

Communication Preferences

Indicate below how you prefer to be notified.

Note: It may be necessary to send some documents via US Postal Service.

***Preferred Communication:**

- I prefer to be notified by e-mail.
- I prefer to be notified by paper mail
- I do not want to receive notifications. I will be reviewing the items in my message center regularly

Cancel

Submit

On the **Personal Profile Information** page, select your preferred method of communication, then select **Submit**.

SDI Online Account Registration Complete

Account Registration Successful

Your SDI Online account has been created and your EDD Customer Account Number is 9123456789. A notification has been sent to you via email.

To access your SDI Online Account, select the Benefit Programs Online link below to log in.

[Benefit Programs Online](#)

Be sure to make a note of your EDD Customer Account Number.

If you selected electronic communication, a notification will be sent to you via email.

If you selected paper mail notification, a letter will be mailed to your address to confirm this account has been created.

You may now select the **Benefit Programs Online** link and log in to access your newly created account.

Access Your Physician/Practitioner Account



Log in to Benefit Programs Online

[En español](#)

Email:

I'm not a robot



reCAPTCHA
[Privacy](#) - [Terms](#)

Log In

Don't have an account? [Register now.](#)

Benefit Programs Online gives you access to these EDD services:

- Unemployment or Pandemic Unemployment Assistance
- Disability
- Paid Family Leave
- Benefit overpayments

To access your account, go directly to the **Benefit Programs Online** page to log in:
edd.ca.gov/BPO.

Enter the email address used to register, complete the security check, and select **Log In**.
You will then be directed to the **Password** page.



▶ Password

To log in to Benefit Programs Online, you must verify your personal image and personal caption, and enter your password.

* Indicates required field.

Personal Image:



Personal Caption: IOU TEST

* Password:

[Forgot Password?](#)

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▶ Benefit Programs Online

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Select UI Online to file a claim for UI benefits or to create or access your UI Online account.

To use UI Online Mobile, you must have already created a UI Online account.

UI Online

UI Online Mobile

SDI Online

SDI Online is a fast, mobile-friendly, and secure way for claimants, physicians/practitioners, physician/practitioner representatives, employers, and voluntary plan administrators to file a new claim, manage a claim, or submit forms online.

Select SDI Online to file a claim for Disability Insurance or Paid Family Leave benefits or to create or access your SDI Online account.

SDI Online

Note: You will be logged out after 30 minutes on any page.

Select **SDI Online**.

CA.GOV Home Benefit Programs Online Utilities Help NNNNNN MMMM Log Out

EDD Employment Development Department State of California

SDI Home Inbox Draft Profile

Home

*Indicates Required Field

License Information

Licensee Name	License Number
John Feelgood	CA00000

Message Center

Inbox [New: 0, Total: 0]
Saved Drafts [Total: 0]

Search

- To submit a Physician/Practitioner's Certificate (DE 2501), search by "Patient/PFL Receipt Number" or "Last 4 digits of SSN."
- To submit additional medical (DE 2525XX, DE 2547A, DE 2547D, or DE 2546), search by "Claim ID" or "Last 4 digits of SSN."
- To view forms you previously submitted, search by "My Receipt Number."
- To submit Paid Family Leave (PFL) - Doctor's Certification search by "Patient/PFL Receipt Number" and use EDD claimant's last name.

*Search By:

*Patient/PFL Last Name:

Date of Birth:

Once you have successfully logged into your account, you will be directed to your SDI Online **Home** page.

The screenshot shows the EDD Home page with a navigation bar at the top containing links for Home, Benefit Programs Online, Utilities, Help, and Log Out. Below the navigation bar, there are links for SDI Home, Inbox, Draft, and Profile. The main content area is titled "Home" and includes a "License Information" section with a table showing License Name (NNNNNN MMMM) and License Number (CA00000). Below this is a "Message Center" section with "Inbox [New: 0, Total: 0]" and "Saved Drafts [Total: 0]". The "Search" section contains instructions for searching by "Patient/PFL Receipt Number", "Claim ID", "My Receipt Number", and "Patient/PFL Receipt Number" and "Doctor's Certification". A search form is highlighted with a red border, featuring a dropdown menu for "Search By" (set to "Claim ID"), a text input for "Patient/PFL Last Name", a date input for "Date of Birth" with a "(MMDD/YYYY)" placeholder, and "Cancel" and "Search" buttons.

On the **Home** page, under the search section, there are four ways to begin searching for certifications and forms:

- Search by “Last 4 digits of SSN” or “Patient Receipt Number” and enter the patient’s date of birth.
- Search by “Claim ID” to submit medical extensions.
- Search by “My Receipt Number” to view forms you have submitted.
- Search by “Patient/PFL Receipt Number” to submit Paid Family Leave forms.

You must also enter the claimant’s last name to begin the search.

The screenshot shows the EDD State of California website interface. At the top, there is a navigation bar with links for Home, Benefit Programs Online, Utilities, Help, NNNNNN MMMM, and Log Out. Below this is a secondary navigation bar with links for SDI Home, Inbox, Draft, and Profile. The main content area includes a 'Home' section with a note '*Indicates Required Field', a 'License Information' section with a table, and a 'Message Center' section. The table in the License Information section has two columns: 'Licensee Name' and 'License Number'. The Message Center section shows 'Inbox [New: 0, Total: 0]' and 'Saved Drafts [Total: 0]'. Below the Message Center is a 'Search' section with instructions and a search form.

Licensee Name	License Number
John Feelgood	CA00000

Message Center

- Inbox [New: 0, Total: 0]
- Saved Drafts [Total: 0]

Search

- To submit a Physician/Practitioner's Certificate (DE 2501), search by "Patient/PFL Receipt Number" or "Last 4 digits of SSN."
- To submit additional medical (DE 2525XX, DE 2547A, DE 2547D, or DE 2546), search by "Claim ID" or "Last 4 digits of SSN."
- To view forms you previously submitted, search by "My Receipt Number."
- To submit Paid Family Leave (PFL) - Doctor's Certification search by "Patient/PFL Receipt Number" and use EDD claimant's last name.

*Search By:

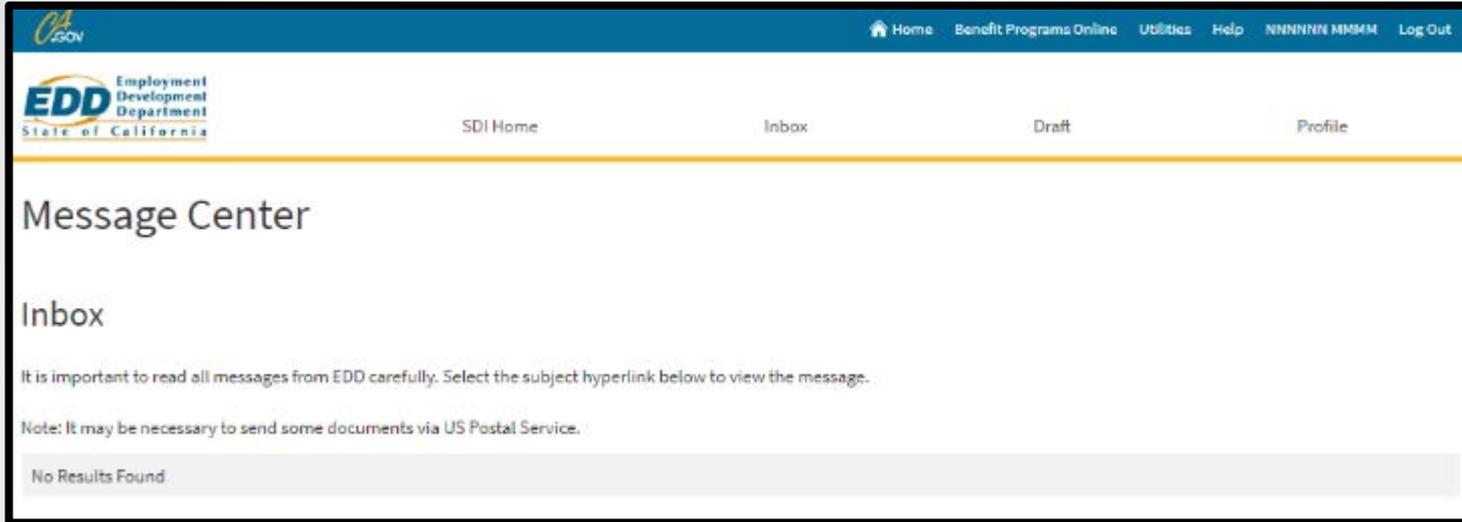
The **Main Menu** appears on most screens and has additional options.

Inbox: Access the Message Center to view messages from the EDD.

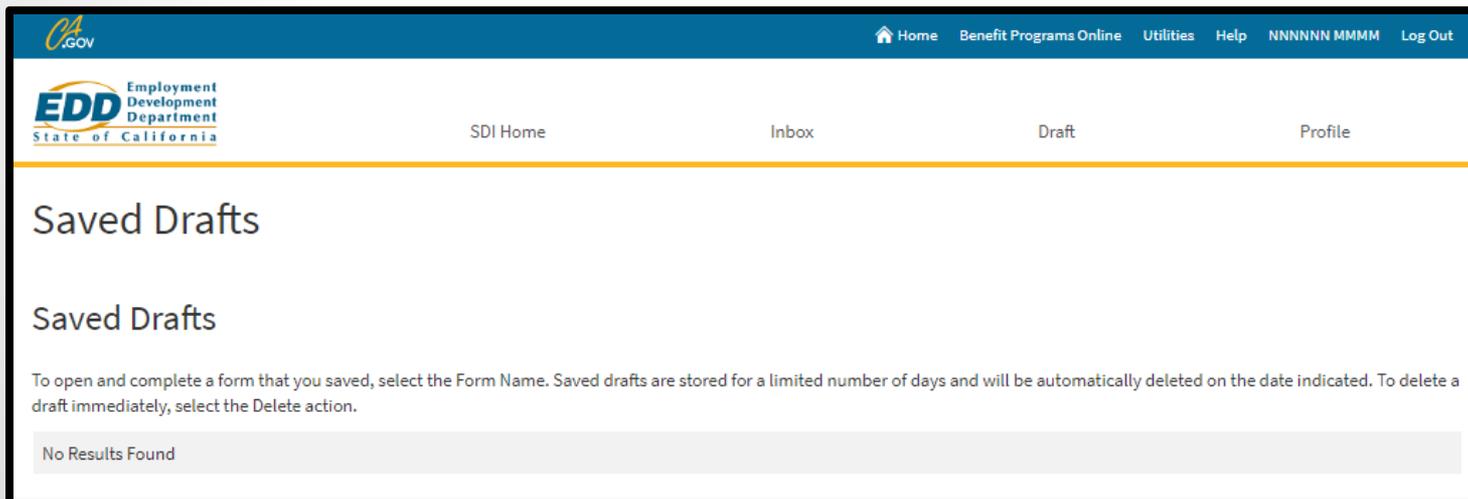
Drafts: View previously saved drafts of forms that were started, but not completed or submitted.

Profile: Update your mailing address, phone number, and preferred.

Inbox: Access the Message Center to view messages from the EDD.



Drafts: View previously saved drafts of forms that were started, but not completed or submitted. **Note:** Saved Drafts are deleted after 30 days.



Add a Treatment Address



Home

*Indicates Required Field

License Information

Licensee Name	License Number
John Feelgood	CA00000

Message Center

[Inbox](#) [New: 0 , Total: 0]

[Saved Drafts](#) [Total: 0]

Search

- To submit a Physician/Practitioner's Certificate (DE 2501), search by "Patient/PFL Receipt Number" or "Last 4 digits of SSN."
- To submit additional medical (DE 2525XX, DE 2547A, DE 2547D, or DE 2546), search by "Claim ID" or "Last 4 digits of SSN."
- To view forms you previously submitted, search by "My Receipt Number."
- To submit Paid Family Leave (PFL) – Doctor's Certification search by "Patient/PFL Receipt Number" and use EDD claimant's last name.

To add a treatment address, select the **Profile** link on your **Home** page **Menu**.

CA.GOV Home Benefit Programs Online Utilities Help Log Out

EDD Employment Development Department State of California SDI Home inbox Draft Profile **Change:**

- Manage Treatment Address
- Manage Medical Representative

Physician/Practitioner Update Personal Profile Information

*Indicates Required Field

Select the Benefit Programs Online link above to update:

- Email Address
- Password
- Security Questions
- Personal Image/Caption

Physician/ Practitioner Information

Address updates must be submitted in writing to the Medical Board with the Department of Consumer Affairs (DCA). DCA will provide EDD with your updated address when the next license validation is done.

Licensee Name: John Feelgood

License Type: Physician or Surgeon (MD)

Physician/Practitioner License Number: CA00000

License Expiration Date: 03-01-2020

Address: 6600 BRUCEVILLE
SACRAMENTO, CA 95823
United States

Phone Number: **Ext:**

Check here if the phone number is international

Medical School Name:

Medical School Year Graduated:

From the Profile Page Menu, hover over **Change** and select **Manage Treatment Address** from the Page Menu.

Treatment Address

Treatment Address

You may have multiple treatment addresses associated with your account. The treatment addresses below will appear as selection options when completing online forms and will allow you to quickly provide your address without having to re-type it.

No Results Found

Add

You will be directed to the **Treatment Address** page. Select the **Add** button to be directed to the Add Modify Treatment Address page.

CA .GOV Home Benefit Programs Online Utilities Help NNNNNN MMMM Log Out

EDD Employment Development Department State of California SDI Home Inbox Draft Profile Change:

Add Modify Treatment Address

*Indicates Required Field

Add/Modify Treatment Address

US International

*Address Line 1:

Address Line 2:

*City:

*State:

*ZIP Code:

*Phone Number: Ext:

Check here if the phone number is international

On the **Add Modify Treatment Address** page, complete all fields and select **Save**.

Note: You will need to repeat this process to add all treatment addresses where you practice.

Treatment Address

Treatment Address

You may have multiple treatment addresses associated with your account. The treatment addresses below will appear as selection options when completing online forms and will allow you to quickly provide your address without having to re-type it.

Address	Phone Number	Action
123 Main Street Folsom, CA 95630-7325 United States	916-444-5555	Modify Delete

Treatment addresses added are displayed on this page.

Select **Modify** or **Delete** to manage your treatment addresses.

To add additional treatment addresses, select **Add**.

Assign a Physician/Practitioner Representative

The screenshot shows the EDD State of California website interface. At the top, there is a blue navigation bar with the CA.GOV logo on the left and links for Home, Benefit Programs Online, Utilities, Help, NNNNNN MMMM, and Log Out on the right. Below this is a white header area with the EDD logo and navigation links for SDI Home, Inbox, Draft, and Profile. A red arrow points to the Profile link. The main content area is titled 'Home' and includes a legend for required fields. Below that is a 'License Information' section with a table showing the licensee name 'John Feelgood' and license number 'CA00000'. There is also a 'Message Center' section with 'Inbox [New: 0, Total: 0]' and 'Saved Drafts [Total: 0]'. At the bottom is a 'Search' section with instructions for finding various forms.

CA.GOV Home Benefit Programs Online Utilities Help NNNNNN MMMM Log Out

EDD Employment Development Department State of California SDI Home Inbox Draft Profile

Home

*Indicates Required Field

License Information

Licensee Name	License Number
John Feelgood	CA00000

Message Center

Inbox [New: 0, Total: 0]
Saved Drafts [Total: 0]

Search

- To submit a Physician/Practitioner's Certificate (DE 2501), search by "Patient/PFL Receipt Number" or "Last 4 digits of SSN."
- To submit additional medical (DE 2525XX, DE 2547A, DE 2547D, or DE 2546), search by "Claim ID" or "Last 4 digits of SSN."
- To view forms you previously submitted, search by "My Receipt Number."
- To submit Paid Family Leave (PFL) – Doctor's Certification search by "Patient/PFL Receipt Number" and use EDD claimant's last name.

Physician/practitioner representatives can complete and submit forms on behalf of the registered physician/practitioner once they have been added to the account.

To add a physician/practitioner representative, select **Profile** from the **Main Menu**.

151.143.100.10(SaveMyPrograms) X SSI Online X +

https://dlsperformance3ext.network11.corp.edd.ca.gov/SDI/PerfR3Ext/Pages/ExternalUser/MedicalProviderUpdatePersonalProfileInformation.aspx?__NodeID=221

CA
EDD Employment Development Department State of California

Home Benefit Programs Online UTILITIES Help Log Out

SDI Home Inbox Draft Profile **Change:**

Manage Treatment Address

Manage Medical Representative

Physician/Practitioner Update Personal Profile Information

*Indicates Required Field

Select the Benefit Programs Online link above to update:

- Email Address
- Password
- Security Questions
- Personal Image/Caption

Physician/ Practitioner Information

Address updates must be submitted in writing to the Medical Board with the Department of Consumer Affairs (DCA). DCA will provide CDD with your updated address when the next license validation is done.

Licensee Name: John Feelgood

License Type: Chiropractor (DC)

Physician/Practitioner License Number: CA00000

License Expiration Date: 12-31-2020

Address: 123 Main St Suite 1
Anytown, CA 95814
United States

Phone Number: 9161234567 Ext:

Check here if the phone number is international

Medical School Name:

Medical School Year Graduated:

From the **Profile Page Menu**, hover over **Change** and select **Manage Medical Representative**.

Add Delete Medical Representative

Medical Representative Information

Please select the Add button to enter a new Medical Representative. To modify or delete a Medical Representative, select the appropriate action. You are still responsible for certifying the medical forms.

No Results Found

Add

On the **Add Delete Medical Representative** page, select **Add**.

Add Modify Medical Representative

*Indicates Required Field

Add Representative

*First Name:

Middle Name:

*Last Name:

Suffix:

*Last 4 Digits of Social Security Number:

*E-mail Address:

*Re-Type E-mail Address:

*Date of Birth:

*Treatment Address:

*Account Status:

Cancel

Save

Complete the required fields and select a treatment address from the drop down menu. Then select **Save**.

Add Delete Medical Representative

Medical Representative Information

Please select the Add button to enter a new Medical Representative. To modify or delete a Medical Representative, select the appropriate action. You are still responsible for certifying the medical forms.

Name	Last 4 Digits of Social Security Number	E-mail Address	Date of Birth	Treatment Address	Account Status	Action
Jane Smith	4564	Jane@gmail.com	05-05-1985	800 d st sacramento CA 95814-0716	Active	Modify Delete

Add

Physician/practitioner representatives added are displayed on this page.

Select **Modify** or **Delete** to manage your medical representatives.

To add additional representatives, select **Add**.

SDI Online Account Registration for Physician/Practitioner Representatives



Registration Success

You have successfully registered for an account. Return to Benefit Programs Online to log in.

[Benefit Programs Online](#)

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Once you have completed your Benefit Programs Online registration, select **Log In** to navigate to the Benefit Programs Online login homepage to complete your SDI Online registration process.



▶ Log in to Benefit Programs Online

[En español](#)

Email:

I'm not a robot



Log In

Don't have an account? [Register now.](#)

Benefit Programs Online gives you access to these EDD services:

- Unemployment or Pandemic Unemployment Assistance
- Disability
- Paid Family Leave
- Benefit overpayments

Enter the email address used to register, complete the security check, and select **Log In**.



▶ Password

To log in to Benefit Programs Online, you must verify your personal image and personal caption, and enter your password.

* Indicates required field.

Personal Image:



Personal Caption: IOU TEST

* Password:

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[Log In](#)

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UI Online

UI Online Mobile

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Select SDI Online to file a claim for Disability Insurance or Paid Family Leave benefits or to create or access your SDI Online account.

SDI Online

Note: You will be logged out after 30 minutes on any page.



To log out of Benefit Programs Online from any page, select the **Log Out** link in the top right hand corner.

After you have logged in, select **SDI Online** link to complete your registration for SDI Online.

SDI Online Registration

Select your account type.

Claimant

Select **Register as a Claimant** to:

- File a Disability Insurance (DI) or Paid Family Leave (PFL) claim.
- Access your claim information.
- View your benefit payment history.

You will need:

- Social Security number
- California driver license (CDL) or identification (ID) card

Note: If you do not have a CDL or ID, you will need to file DI by mail or file PFL by mail.

Claimant registration is available from Monday to Saturday 6 a.m. to 6 p.m. and Sunday 6 a.m. to 5:30 p.m.

Register as a Claimant

Employer

Select **Register as an Employer** if you represent an employer.

You will need:

- Employer Account Number (EAN)
- Employer ZIP Code (as filed with the EDD Tax Branch)
- Total Subject Wages from the most recent DE 9C

Register as an Employer

Physician/Practitioner

Select **Register as a Physician/Practitioner** to certify Disability Insurance (DI) or Paid Family Leave (PFL) claims for your patients.

You will need:

- Medical license information (as filed with the California Department of Consumer Affairs)
- California driver license (CDL) or identification (ID) card

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Register as a Physician/Practitioner

Physician/Practitioner Representative

Select **Register as a Representative** if a physician/practitioner designated you as their representative to certify Disability Insurance (DI) or Paid Family Leave (PFL) claims for their patients through SDI Online.

Note: You must match the information entered by the physician/practitioner.

Register as a Representative



You will be directed to the **SDI Online Registration Options** page.

Select the link for **Physician/practitioner Representative Registration**.

Physician/Practitioner Representative: Terms and Conditions

Terms and Conditions

Please read through the entire Terms and Conditions before proceeding. The information you provide may be used to verify your identity with federal and/or state agencies. If “I Do Not Agree” is selected, you will not be able to establish an online account.

These Terms and Conditions, which include the Conditions of Use and Privacy Statements, govern the use of and access to: (i) this website (www.edd.ca.gov/); and (ii) the information on or provided through this website.

If you establish an online account you are responsible for maintaining the confidentiality of your username and password, and you are responsible for all activities which you authorize under your username and password. You agree to: (i) immediately notify the Employment Development Department (EDD) of any unauthorized use of your username and password or any other breach of security; and (ii) log out from your account at the end of each session.

By registering for an online account, you agree to check your account regularly and frequently for messages from the EDD. Please note that e-mails will only be used to send notifications to log in to your account or when you request to reset your username or password. No confidential claim information will be sent via e-mail.

The information submitted by any party will be used by the Employment Development Department to carry out its responsibilities under the California Unemployment Insurance Code, which may include the sharing of the information with other entities as required by law.

These Terms and Conditions may change from time to time and it is your responsibility to check for updates. The last revision date for these Terms and Conditions is February 1, 2012.

I have read and understand all the above information and wish to continue with establishing an account in the State Disability Insurance (SDI) Online.

You must agree to the terms and conditions to continue. Select **I Agree**.

Physician/Practitioner Representative: Account Verification Information

*Indicates Required Field

To register for a new SDI Online account, provide the following information.

Physician/Practitioner Representative Information

Please enter your name as provided to the EDD by the medical provider authorizing your account.

*First Name:

Middle Name:
(If you have no middle name, leave blank.)

*Last Name:

Suffix:
(If you have no suffix, leave blank.)

E-mail Address: WTMPRREG43@Edd.ca.gov

*Date of Birth:
(MMDDYYYY)

*Last four digits of Social Security Number:

Cancel

Next

Complete the physician/practitioner representative information section. Be sure to enter your name exactly as provided to the EDD by the physician/practitioner authorizing your account, then select **Next**.

Physician/Practitioner Representative: Personal Profile Information

*Indicates Required Field

Physician/Practitioner Representative Information

Treatment Address: 10833 Folsom Blvd
Rancho Cordova, CA 95670-5000
United States

***Phone Number:** **Ext:**

Check here if the phone number is international

Communication Preferences

Indicate below how you prefer to be notified.

Note: It may be necessary to send some documents via US Postal Service.

- *Preferred Communication:**
- I prefer to be notified by e-mail.
 - I prefer to be notified by paper mail
 - I do not want to receive notifications. I will be reviewing the items in my message center regularly

Cancel

Submit

Verify the treatment address, enter the phone number, and select your preferred method of communication, then select **Submit**.

Note: The physician/practitioner can change the fields that a physician/practitioner representative cannot.

SDI Online Account Registration Complete

Account Registration Successful

Your SDI Online account has been created and a notification has been sent to you via email.

To access your SDI Online Account, select the Benefit Programs Online link below to log in.

[Benefit Programs Online](#)

A letter will be mailed to the physician's/practitioner's address to confirm this account has been created.

If you selected electronic communication, a notification will also be sent to you via email.

Select the **Benefit Programs Online** link and log in to begin working on a physician/practitioner account.



▶ Log in to Benefit Programs Online

[En español](#)

Email:

I'm not a robot



reCAPTCHA
Privacy - Terms

Log In

Don't have an account? [Register now.](#)

Benefit Programs Online gives you access to these EDD services:

- Unemployment or Pandemic Unemployment Assistance
- Disability
- Paid Family Leave
- Benefit overpayments

Enter the email address used to register, complete the security check, and select **Log In**. You will then be directed to the **Password** page.



▶ Password

To log in to Benefit Programs Online, you must verify your personal image and personal caption, and enter your password.

* Indicates required field.

Personal Image:



Personal Caption: IOU TEST

* Password:

[Forgot Password?](#)

Previous

Log In

Enter the password you created during the registration process and select **Log In**.

If you do not recognize your personal image and caption, review the email address entered on the login screen to make sure it is correct. Call 1-800-480-3287 for further assistance.

Choose Physician/Practitioner

Physician/Practitioner Representative Choose Physician/Practitioner

You are authorized to perform work in the State Disability Insurance (SDI) Online system for the physician/practitioner(s) listed below. Please select the physician/practitioner for which you wish to perform work. You may only perform work for one physician/practitioner per log in. You will need to log out to select a different physician/practitioner.

Physician/Practitioner	New Action Required	Total Action Required	Saved Drafts
John Feelgood	19	20	0
Bob Smith	18	20	0
Jane Doe	20	20	0

You may now select the physician/practitioner account you wish to work on.

Home

*Indicates Required Field

License Information

Licensee Name	License Number
John Feelgood	CA00000



Message Center

Inbox [New: 19 , Total: 20]

Saved Drafts [Total: 0]

Search

- To submit a Physician/Practitioner's Certificate (DE 2501), search by "Patient/PFL Receipt Number" or "Last 4 digits of SSN."
- To submit additional medical (DE 2525XX, DE 2547A, DE 2547D, or DE 2546), search by "Claim ID" or "Last 4 digits of SSN."
- To view forms you previously submitted, search by "My Receipt Number."
- To submit Paid Family Leave (PFL) - Doctor's Certification search by "Patient/PFL Receipt Number" and use EDD claimant's last name.

*Search By:

*Patient/PFL Last Name:

Date of Birth:

You will then be directed to the physician/practitioner's Home page.

Submit a DE 2501 Part B – Physician's/Practitioner's Certificate

Home

*Indicates Required Field

License Information

Licensee Name	License Number
John Feelgood	CA00000

 Message Center

[Inbox](#) [New: 19 , Total: 20]

[Saved Drafts](#) [Total: 0]

Search

- To submit a Physician/Practitioner's Certificate (DE 2501), search by "Patient/PFL Receipt Number" or "Last 4 digits of SSN."
- To submit additional medical (DE 2525XX, DE 2547A, DE 2547D, or DE 2546), search by "Claim ID" or "Last 4 digits of SSN."
- To view forms you previously submitted, search by "My Receipt Number."
- To submit Paid Family Leave (PFL) - Doctor's Certification search by "Patient/PFL Receipt Number" and use EDD claimant's last name.

*Search By:

*Patient/PFL Last Name:

Date of Birth:

On the **Home** page, under the **Search** section, there are two ways search for the DE 2501B to find your patient's claim:

- Search by "Patient Receipt Number."
- Search by the last four digits of the patient's SSN and Date of Birth.

You must also enter the patient's last name to begin the search.

In order to submit the DE 2501 Part B online, the patient must have already submitted the DE 2501 Part A – Claimant's Statement.

Choose Physician/Practitioner

Physician/Practitioner Representative Choose Physician/Practitioner

You are authorized to perform work in the State Disability Insurance (SDI) Online system for the physician/practitioner(s) listed below. Please select the physician/practitioner for which you wish to perform work. You may only perform work for one physician/practitioner per log in. You will need to log out to select a different physician/practitioner.

Physician/Practitioner	New Action Required	Total Action Required	Saved Drafts
John Feelgood	19	20	0
Bob Smith	18	20	0
Jane Doe	20	20	0

On the **Home** page, select the physician/practitioner you are submitting the DE 2501B on behalf of.

You may select only one physician/practitioner at a time.

You may switch to a different physician/practitioner account by selecting **Home** from the **Main Menu** and selecting **Choose Physician/Practitioner**.

Search

- To submit a Physician/Practitioner's Certificate (DE 2501), search by "Patient/PFL Receipt Number" or "Last 4 digits of SSN."
- To submit additional medical (DE 2525XX, DE 2547A, DE 2547D, or DE 2546), search by "Claim ID" or "Last 4 digits of SSN."
- To view forms you previously submitted, search by "My Receipt Number."
- To submit Paid Family Leave (PFL) – Doctor's Certification search by "Patient/PFL Receipt Number" and use EDD claimant's last name.

*Search By:

*Patient/PFL Last Name:

Date of Birth:

Search Results

Receipt Number	Patient/PFL Name	Date of Birth	Action
R100000000033667	Jane Doe	01-01-1990	Submit Physician/Practitioner Certificate

Select a preferred search method from the **Search By** drop down menu.

Verify the information in the **Search Results** section matches the patient's records.

The **Receipt Number** link will allow you to view what the patient submitted on their portion of the DE 2501 Part A – Claimant's Statement.

Select the **Submit Physician/Practitioner Certificate** link under the action column.

Note: If the certificate is already submitted by another user (i.e., physician/practitioner representative), the **Submit Physician/Practitioner Certificate** link will not be available.

CA.GOV Home Benefit Programs Online Utilities Help Log Out

EDD Employment Development Department State of California SDI Home Inbox Draft Profile

View Claimant Portion

View Claimant DE 2501

Refer to the *Claim for Disability Insurance (DI) Benefits (DE 2501) Claimant's Statement* while completing this form. To open the Claimant's Statement, select the hyperlink below and it will open in a new window.

[View the Claim for Disability Insurance \(DI\) Benefits Claimant \(DE 2501\)](#)

Cancel Next

On the **View Claimant Portion**, you may select the link to view the claimant portion of the form.

Select **Next** to complete the certificate.

CA.GOV Home Benefit Programs Online Utilities Help Log Out

EDD Employment Development Department State of California SDI Home Inbox Draft Profile

Treatment Address

1 Treatment Address 2 Patient Information 3 Claim Information 4 Declaration

You are currently on Step 1 Treatment Address

Section 2B - Treatment Address

Select the address where the patient was treated. If the patient was treated at an address other than those shown below, select 'Not Found' and you will be prompted to enter a new treatment address.

Address	Action
6800 BRUCEVILLE RD Sacramento, CA 95823-4671 United States	Select

Previous Cancel Not Found

On the **Treatment Address** page, select the treatment address of where the patient is being treated.

Initial Questions

1 Treatment Address | **2 Patient Information** | 3 Claim Information | 4 Declaration

You are currently on Step 2 Patient Information

*Indicates Required Field

Section 1 - Patient Information

Patient's Name:
 Receipt Number:
 Social Security Number:
 Date of Birth:
 Title Number:

Section 2A - Physician/Practitioner Information

Name: John Feelgood
 Treatment Address: 7500 Hospital Dr.
 Sacramento, CA 95823
 United States

License Number: AB5296
 State of License: CA00000
 Country of License: United States

*Phone Number: Ext:
 Check here if the phone number is international

Type: Physician or Surgeon (MD)
 Specialty (if any):

Section 3 - Treatment Information

This patient has been under my care and treatment for this medical problem:

*From:
 To:

*Are you presently treating the patient for this medical condition? Yes No

Treatment Interval:

*Has the patient been previously by another physician/practitioner or medical facility for the current disability/illness/injury?

If "Yes," enter date of first treatment:

*At any time during your attendance for this medical problem, has the patient been incapable of performing his/her regular or customary work? Yes No

Complete the **Patient Information** section.

Mandatory fields are marked with a red asterisk (*).

Note: Do not use the **Back** button on the browser. If you need to go to a previous screen, select the **Previous** button.

Tip: Select **Save as Draft** at any point in the process to complete the form at a later time.

Section 2A - Physician/Practitioner Information

Name: John Feelgood

Treatment Address: 7500 Hospital Dr.
Sacramento, CA 95823
United States

License Number: CA00000

State of Licensure: CA

Country of Licensure: United States

*Phone Numbers: Ext:
 Check here if the phone number is international

Type: Physician or Surgeon (MD)

Specialty (if any):

Section 3 - Treatment Information

This patient has been under my care and treatment for this medical problem:

*From:

To:

*Are you presently treating the patient for this medical condition? Yes No

Treatment Intervals:

*Was the patient seen previously by another physician/practitioner or medical facility for the current disability/illness/injury?

If "Yes," enter date of first treatment:

*At any time during your attendance for this medical problem, has the patient been incapable of performing his/her regular or customary work? Yes No

When all fields are complete, select **Next**.

Note: Marking **No** will end your submission and make patient ineligible for benefits.

Tip: Select **Save as Draft** at any point in the process to complete the form at a later time.

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EDD Employment Development Department State of California

SDI Home Inbox Draft Profile

Claim Information

Treatment Address
 Patient Information
 3 Claim Information
 4 Declaration

You are currently on Step 3 Claim Information

*Indicates Required Field

Section 4A - Claim Information

*Date Disability Began: (MMDDYYYY)

Indicate if the disability was caused by accident or trauma; and if so, indicate the date the accident or trauma occurred below:

*Accident or trauma? Yes No

Date occurred: (MMDDYYYY)

Complete the **Claim Information** sections 4A and 5.

Mandatory fields are marked with a red asterisk (*).

Diagnosis Code Version: Select

ICD Diagnosis Code:

Diagnosis Code Version: Select

ICD Diagnosis Code:

Diagnosis Code Version: Select

*Diagnosis - If no diagnosis has been determined, enter a detailed statement of symptoms:

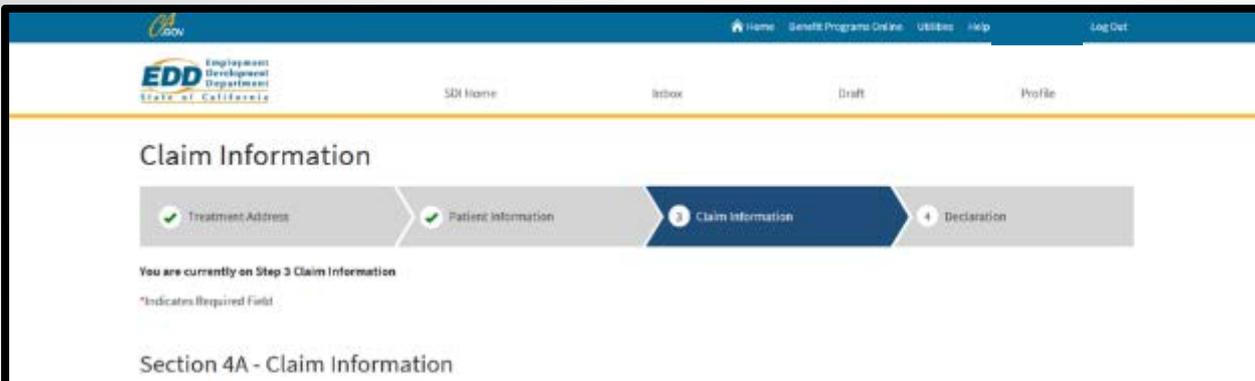
Findings - State nature, severity, and extent of the incapacitating disease or injury, include any other disabling conditions:

Type of treatment/medication rendered to patient:

If the patient was hospitalized, enter the date of entry, date of discharge and whether the patient is still hospitalized below:

Date of entry: (MMDDYYYY)

Date of discharge: (MMDDYYYY)



SDI Online will accept valid ICD-9 and ICD-10 codes.

For non-pregnancy related claims, you must provide the following date or indicate the disability is permanent.

Date you released or anticipate releasing patient to return to his/her regular or customary work: (MMDDYYYY)

Check here to indicate patient's disability is permanent and you never anticipate releasing patient to return to his/her regular or customary work:

Enter the ICD Diagnosis Code and version for the primary disabling condition that prevents the patient from performing his/her regular or customary work below:

*ICD Diagnosis Code: [Text Box]

*Diagnosis Code Version: [Select]

ICD Diagnosis Code(s) for Secondary Disabling Condition(s):

ICD Diagnosis Code: [Text Box]

Diagnosis Code Version: [Select]

ICD Diagnosis Code: [Text Box]

Diagnosis Code Version: [Select]

ICD Diagnosis Code: [Text Box]

Diagnosis Code Version: [Select]

*Diagnosis - If no diagnosis has been determined, enter a detailed statement of symptoms: [Text Box]

Findings - State nature, severity, and extent of the incapacitating disease or injury. Include any other disabling conditions: [Text Box]

Type of treatment/medication rendered to patient: [Text Box]

If the patient was hospitalized, enter the date of entry, date of discharge and whether the patient is still hospitalized below:

Date of entry: (MMDDYYYY) [Text Box]

Date of discharge: (MMDDYYYY) [Text Box]

If the patient's disability is diagnosed as permanent and you have selected the "permanent disability" box, you do **not** need to provide a date in the "Date you released or anticipate releasing patient to return to his/her regular or customary work" field.

In the "Findings" field, please provide a detailed description of why you consider the disability to be permanent.

Patient is still hospitalized? Yes No

Check here if the patient is deceased:

Date of death:

City:

Country:

State:

Enter type and date of surgery/procedure most recently performed or to be performed below:

Type:

Date:

Continue completing the Claim Information.

Mandatory fields are marked with a red asterisk (*).

Procedure Code Version:

Enter the CPT code for surgery/procedure(s) planned or performed below:

CPT Code:

CPT Code:

CPT Code:

CPT Code:

Was the patient unable to work immediately prior to the surgery or procedure? Yes No

If "Yes," please provide the first date the patient was unable to work prior to the surgery or procedure:

*Was this disabling condition caused and/or aggravated by the patient's regular or customary work? Yes No

*Are you completing this form for the sole purpose of referral/recommendation to an alcoholic recovery home or drug-free facility (as indicated by the patient on the DE 2501 Claim for Disability Insurance (DI) Benefits Claimant's Statement)? Yes No

Date your patient became a resident of a drug or alcohol facility (if known):

*Would disclosure of the information on this form to your patient be medically or psychologically detrimental? Yes No

*Is this a pregnancy related claim? Yes No

Section 5 - Pregnancy

Estimated Delivery Date:

Pregnancy End Date (if applicable):

If this patient has not delivered and you do not anticipate releasing the patient to return to regular or customary work prior to the estimated delivery date, provide estimates for the number of days you anticipate the patient will be disabled after delivery for both of the following delivery types:

Vaginal delivery:

Cesarean delivery:

If this patient has delivered, indicate type of delivery and any complications as applicable.

Type of delivery:

If pregnancy is/was abnormal, state the complication(s) causing maternal disability:

Physicians/practitioners can provide an estimated number of days they anticipate the patient to be disabled postpartum.

➤ Example: If the physician/practitioner allows the patient 6-8 weeks of postpartum disability, depending on the delivery type, then:

- Enter the number 42 in the Vaginal Delivery field (6 weeks x 7 days a week = 42)

OR

- Enter the number 56 in the Cesarean Delivery field (8 weeks x 7 days a week = 56).

Select **Next**.

CA GOV Home Benefit Programs Online Utilities Help Log Out

EDD Employment Development Department State of California SDI Home Inbox Draft Profile

ICD Code Summary

Treatment Address Patient Information **3 Claim Information** 4 Declaration

You are currently on Step 3 Claim Information

Section 4B - ICD Code Summary

Type	ICD Code	Version	Diagnosis	Action
Primary Diagnosis Code	847	ICD-9	Sprains and Strains of Other and Unspecified Parts of Back	Delete

Previous Cancel Save as Draft **Next**

Verify the ICD code(s) is correct for the claim and select **Next**.

If it is not correct, select **Delete** and re-input the correct code(s) in the **Claim Information** section.

Additional Information



You are currently on Step 3 Claim Information

*Indicates Required Field

Section 6 - Prognosis Information

*What complications make your patient disabled longer than normally expected?

Previous

Cancel

Save as Draft

Next

Complete section 6 and select **Next**.

Certification



You are currently on Step 4 Declaration

*Indicates Required Field

Section 7 - Certification

I certify under penalty of perjury that the patient is unable to perform his/her regular or customary work because of the listed disabling condition(s). I have performed a physical examination and/or treated the patient within my scope of practice as an authorized physician or practitioner pursuant to California Unemployment Insurance Code Section 2708.

To review your information before you submit, select the hyperlink below. Your information will display below the Claimant's Statement.

[View the Claim for Disability Insurance \(DI\) Benefits Physician/Practitioner Certification \(DE 2501\)](#)

Previous

Cancel

Save as Draft

Submit

Once the form is completed, select the box in the **certification** section to authorize an electronic signature. Before submitting the form, you may view the form by selecting the link at the bottom of the page.

Select **Submit**. You will be directed to the **Confirmation** page and provided a form receipt number.

Confirmation

Confirmation

Please print this page for your records. If a printer is unavailable at this time, please record the Form Receipt Number below. The Form Receipt Number is required to retrieve a copy of the *Claim for Disability Insurance (DI) Benefits* (DE 2501). You will not be able to access your confirmation page and Form Receipt Number after this window is closed.

Form Receipt Number: [R100000000035745](#)

On the **Confirmation** screen, select the **Form Receipt Number** link to open a PDF printer-friendly view of the information that is submitted.

Submit an online DE 2525XX
Supplemental Medical Certificate
for Continued Benefits

The screenshot shows the EDD Home page with a navigation bar at the top containing 'Home', 'Benefit Programs Online', 'Utilities', 'Help', and 'Log Out'. Below the navigation bar are links for 'SDI Home', 'Inbox', 'Draft', and 'Profile'. The main content area is titled 'Home' and includes a note: '*Indicates Required Field'. Under 'License Information', there is a table with two columns: 'Licensee Name' (John Feelgood) and 'License Number' (CA00000). Below this is a 'Message Center' section with 'Inbox [New: 0, Total: 0]' and 'Saved Drafts [Total: 0]'. A red box highlights the 'Search' section, which contains instructions and a search form. The instructions are: '- To submit a Physician/Practitioner's Certificate (DE 2501), search by "Patient/PFL Receipt Number" or "Last 4 digits of SSN."' '- To submit additional medical (DE 2525XX, DE 2547A, DE 2547D, or DE 2546), search by "Claim ID" or "Last 4 digits of SSN."' '- To view forms you previously submitted, search by "My Receipt Number."' '- To submit Paid Family Leave (PFL) - Doctor's Certification search by "Patient/PFL Receipt Number" and use EDD claimant's last name.'

***Search By:**

***Patient/PFL Last Name:**

Date of Birth:

On the **Home** page, to submit a DE 2525XX – Supplemental Medical Certificate:

Select a preferred search method from the **Search By** drop down menu.

Search

- To submit a Physician/Practitioner's Certificate (DE 2501), search by "Patient/PFL Receipt Number" or "Last 4 digits of SSN."
- To submit additional medical (DE 2525XX, DE 2547A, DE 2547D, or DE 2546), search by "Claim ID" or "Last 4 digits of SSN."
- To view forms you previously submitted, search by "My Receipt Number."
- To submit Paid Family Leave (PFL) – Doctor's Certification search by "Patient/PFL Receipt Number" and use EDD claimant's last name.

*Search By: Last 4 digits of SSN

*Patient/PFL Last Name:

Date of Birth:

Claim(s) Pending Physician/Practitioner's Certificate (DE 2501 or DE 2501F)

No Results Found

Claim(s) Available to Submit Additional Medical Information (DE 2525XX, DE 2547A, DE 2547D, or DE 2546)

Claim ID	Patient/PFL Name	Claim Effective Date	Action
DI1000020270	Jane Doe	11-01-2018	Submit Additional Medical Information

Verify the information in the **Search Results** section matches the patient's records.

Then select the **Claim ID** link.

Claim Summary

Claim Summary

Claimant Name: Jane Doe
Claim Effective Date: 11-01-2018

Claim ID: DI-1000-020-270

 My Message Center Regarding Jane Doe

Inbox [New: 0, Total: 0]

Saved Drafts [Total: 0]

My Forms Available to Submit for Jane Doe

Below is a list of forms available for submission. Please note that not all forms will be available at all times. If a form for the same dates has already been submitted or mailed, do not submit a duplicate form. Please allow 5-7 business days for the form to be processed.

[2525XX Supplemental Medical Cert](#)

My Forms Submitted for Jane Doe

No Results Found

Under the **My Forms Available to Submit** section, select the **2525XX Supplemental Medical Cert** link.

Physician/Practitioner Supplementary Certificate (Part 1)

*Indicates Required Field

Section 1 - Physician/Practitioner Information

Section 4A - Physician/Practitioner's Supplementary Certificate

Patient File Number:

Specialty, if any:

*Are you still treating the patient? Yes No

*Date of last treatment:

Next Appointment Date:

What present condition continues to make the patient disabled?

Enter the ICD Diagnosis Code and version for the primary disabling condition that prevents the patient from performing his/her regular or customary work below:

ICD Diagnosis Code:

Diagnosis Code Version:

Enter the ICD Diagnosis Code and version for secondary disabling condition (s) that prevents the patient from performing his/her regular or customary work below:

ICD Diagnosis Code:

Diagnosis Code Version:

ICD Diagnosis Code:

Diagnosis Code Version:

ICD Diagnosis Code:

Diagnosis Code Version:

Describe how the patient's present condition/impairment prevents him/her from returning to his/her regular or customary work:

What factors or complications are disabling the patient longer than previously estimated for this type of illness or injury?

Cancel

Save as Draft

Next

Complete the **Physician/Practitioner Supplementary Certificate Part 1** then select **Next**.

Mandatory fields are marked with a red asterisk (*).



[Home](#)
[Benefits Programs Online](#)
[LISERS](#)
[Help](#)
[Out](#)

[SDI Home](#)
[Inbox](#)
[Draft](#)
[Profile](#)

Physician/Practitioner Supplementary Certificate (Part 2)

*Indicates Required Field

Section 4B - Physician/Practitioner's Supplementary Certificate

***Was the patient hospitalized?** Yes No

If "Yes", provide the following:

Date of Entry:

Date of Discharge:

Check here if patient is still hospitalized

***Was surgery/procedure performed, or will a surgery/procedure be performed?** Yes No

If "Yes", type of surgery/procedure:

Date of surgery/procedure:

Enter the ICD Procedure Code and version for the surgery/procedure(s) planned or performed below:

ICD Procedure Code:

Procedure Code Version:

ICD Procedure Code:

Procedure Code Version:

Enter the CPT Code for the surgery/procedure(s) planned or performed below:

CPT Code:

CPT Code:

CPT Code:

CPT Code:

Present estimated date patient will be able to perform his/her regular or customary work:

Check here to indicate patient's disability is permanent and you never anticipate releasing patient to return to his/her regular or customary work:

***Would the disclosure of this information to your patient be medically or psychologically detrimental?** Yes No

Complete the **Physician/Practitioner Supplementary Certificate Part 2** then select **Next**.

Mandatory fields are marked with a red asterisk (*).

CA .GOV Home Benefit Programs Online Utilities Help Log Out

EDD Employment Development Department State of California SDI Home Inbox Draft Profile

Treatment Address

Treatment Address

Select the address where the patient was treated. If the patient was treated at an address other than those shown below, select 'Not Found' and you will be prompted to enter a new treatment address.

Address	Action
7500 Hospital Dr. Sacramento, CA 95823 United States	Select

Previous Cancel Not Found

On the **Treatment Address** page, select the treatment address of where the patient was treated.

CA.GOV Home Benefit Programs Online Utilities Help Log Out

EDD Employment Development Department State of California SDI Home Inbox Draft Profile

Submit Form

*Indicates Required Field

Section 5 - Certification

Submitted by: John Feelgood

I certify under penalty of perjury that the patient is unable to perform his/her regular or customary work because of the listed disabling condition(s). I have performed a physical examination and/or treated the patient within my scope of practice as an authorized physician or practitioner pursuant to California Unemployment Insurance Code Section 2708.

Previous Cancel Save as Draft Submit

Once the form is completed, select the box in the **certification** section to authorize an electronic signature.

Select **Submit**. You will be directed to the **Confirmation** page and provided a form receipt number.



Confirmation

Form Successfully Submitted

Please print this page for your records. If a printer is unavailable at this time, please record the Form Receipt Number below. The Form Receipt Number is required to retrieve a copy of the *Physician/Practitioner's Supplementary Certificate (DE 2525XX)*. You will not be able to access your confirmation page and Form Receipt Number after this window is closed.

Form Receipt Number: [R100000000035792](#)

On the **Confirmation** screen, select the **Form Receipt Number** link to open a PDF printer-friendly view of the information that is submitted.

Submit a Physician/practitioner Certificate for a PFL Care Claim

Home

License Information

Licensee Name	License Number
John Feelgood	CA12345

Message Center

Inbox [New: 0, Total: 0]

Saved Drafts [Total: 0]

Search

- To submit a Physician/Practitioner's Certificate (DE 2501), search by "Patient/PFL Receipt Number" or "Last 4 digits of SSN."
- To submit additional medical (DE 2525XX, DE 2547A, DE 2547D, or DE 2546), search by "Claim ID" or "Last 4 digits of SSN."
- To view forms you previously submitted, search by "My Receipt Number."
- To submit Paid Family Leave (PFL) - Doctor's Certification search by "Patient/PFL Receipt Number" and use EDD claimant's last name.

*Search By: Patient/PFL Receipt Number

*Patient/PFL Last Name:

Date of Birth:

Search Results

Receipt Number	Patient/PFL Name	Date of Birth	Action
R10000000012345	Johnny Johnson	01-01-1990	Submit Physician/Practitioner Certificate

On the **Home** page, under the **search** section, you may search for your patient's care provider's PFL claim:

- Search by "Patient/PFL Receipt Number" to submit PFL forms for your patient's care provider.
- Search by the last four digits of the patient's SSN, date of birth, and last name.

You must also enter the patient's care provider's last name to begin the search.

Note: In order to submit the physician/practitioner portion of the DE 2501F online, the patient's care provider must have already submitted their part of the DE 2501F.

CA.GOV

Home Benefit Programs Online Utilities Help Log Out

EDD Employment Development Department State of California

SDI Home Inbox Draft Profile

View Claimant Portion

*Indicates Required Field

View Claimant DE 2501F

If the person identified below (care recipient) is NOT your patient, do not complete or submit this form. To view the form information submitted by your patient's care provider, please select the hyperlink below.

[View Claim for Paid Family Leave \(PFL\) Benefits \(DE 2501F\) for Care](#)

Claimant (Care Provider) Name: Sue Johnson Claimant Social Security Number: XXX-XX-XXXX

Patient (Care Recipient) Name: Johnny Johnson Patient Date of Birth: 01-01-1969

*Do you have the patient's (care recipient's) Health Insurance Portability and Accountability Act (HIPAA) authorization to submit their medical information to EDD? Yes No

Cancel Next

In the **View Claimant DE 2501F** section, you may select the link to view the claimant portion of the form.

Select **Next** to complete the certificate.

CA GOV Home Benefit Programs Online Utilities Help Log Out

EDD Employment Development Department STATE OF CALIFORNIA SDI Home Inbox Draft Profile

Treatment Address

1 Treatment Address 2 Initial Questions 3 Medical Information 4 Certification

You are currently on Step 1 Treatment Address

Treatment Address

Select the address where the patient (care recipient) was treated. If the patient (care recipient) was treated at an address other than those shown below, select 'Not Found' and you will be prompted to enter a new treatment address.

You should only submit this form online if you have used your California medical license to treat the patient (care recipient).

Address	Action
1000 Main St San Francisco, CA 94115 United States	Select

Previous Cancel

On the **Treatment Address** page, select the treatment address of where the patient is being treated.

CA
GOV

Home Benefit Programs Online Utilities Help Log Out

EDD Employment Development Department State of California

SDI Home Inbox Draft Profile

Initial Questions

1 Treatment Address 2 Initial Questions 3 Medical Information 4 Certification

You are currently on Step 2 Initial Questions

*Indicates Required Field

Physician/ Practitioner Information

Name: John Feelgood

State License Number: CA12345

Treatment Address: 1000 Main St
San Francisco, CA 94115
United States

State of Licensure: CA

*Phone Number: 4154445555 Ext:

Check here if the phone number is international

Type of Physician/Practitioner: Physician or Surgeon (MD)

Specialty (if any):

Care Required Information

Claimant (Care Provider) Name: Sue Johnson

Patient (Care Recipient) Name: John Johnson

Claimant Social Security Number: XXX-XX-XXXX

Patient Date of Birth: 01-01-1969

*Does your patient (care recipient) require care by the Paid Family Leave claimant (care provider) entered above? Yes No

Previous Cancel Save as Draft **Next**

Verify the information showing is correct and complete the **Physician/Practitioner Information** section and select **Next**.

Mandatory fields are marked with a red asterisk (*).

[Home](#)
[Benefit Programs Online](#)
[Utilities](#)
[Help](#)
[Log Out](#)

[SDI Home](#)
[Inbox](#)
[Draft](#)
[Profile](#)

Medical Information

✓ Treatment Address
✓ Initial Questions
3 Medical Information
4 Certification

You are currently on Step 3 Medical Information

*Indicates Required Field

Medical Information

Enter the ICD Diagnosis Code and version for the primary serious health condition for which the patient (care recipient) requires care from the claimant (care provider)

*ICD Diagnosis Code:

*Diagnosis Code Version:

Secondary ICD Code(s) and Version(s)

ICD Code:

Code Version:

ICD Code:

Code Version:

ICD Code:

Code Version:

*Diagnosis, or if not determined, a detailed statement of symptoms:

Date patient's condition commenced:

*First date care needed:

Date you estimate patient will no longer require care by the claimant:

Permanent Care Required

Date you expect recovery:

Never

Approximately how many total hours per day will patient (care recipient) require care by a Paid Family Leave claimant (care provider)

*Hours:

Comments:

SDI Online will accept valid ICD-9 and ICD-10 codes.

Complete all applicable fields, then select **Next**.

The screenshot shows the EDD Certification form interface. At the top, there is a navigation bar with links for Home, Benefit Programs Online, Utilities, Help, and Log Out. Below this is the EDD logo and navigation links for SDI Home, Inbox, Draft, and Profile. The main heading is "Certification". A progress bar shows four steps: Treatment Address, Initial Questions, Medical Information, and Certification (the current step). Below the progress bar, it states "You are currently on Step 4 Certification" and includes a note: "*Indicates Required Field". The "Detrimental Medical" section contains a question: "*Would disclosure of the medical information on this certificate be medically or psychologically detrimental to your patient?" with radio buttons for Yes and No. The "Certification" section features a red-bordered checkbox with the text: "I certify under penalty of perjury that this patient has a serious health condition and requires a care provider. I have performed a physical examination and/or treated the patient, I am authorized to certify a patient disability or serious health condition pursuant to California Unemployment Insurance Code Section 2708." Below this is a note: "To review the information you have entered, right click on the hyperlink and select 'Open in New Window.' Then select Save." and a link: "View Claim for Paid Family Leave (PFL) Benefits (DE 2501F) for Care". At the bottom, there are buttons for Previous, Cancel, Save as Draft, and Submit (the Submit button is highlighted with a red border).

Once the form is completed, select the box in the **Certification** section to authorize an electronic signature.

Before submitting the form, you may view the form by selecting the link at the bottom of the page.

Select **Submit**. You will be directed to the **Confirmation** page and provided a form receipt number.



Confirmation

Confirmation

The form has been successfully submitted. Please record the receipt number for your records. You may access this form from your home page by searching with the receipt number.

Form Receipt Number: R1000000012345

On the **Confirmation** screen, select the **Form Receipt Number** link to open a PDF printer-friendly view of the information that is submitted.

Submit a Paper Claim Form

To avoid delays in claims processing, complete the form as follows:

- Use black ink only.
- Type or write clearly **within** the boxes provided.
- Fill out only the physician's/practitioner's portion of the form:
 - Part B of the *Claim for Disability Insurance (DI) Benefits* (DE 2501)
 - Page D of the *Claim for Paid Family Leave (PFL) Benefits* (DE2501F)
- Provide only one medical license number. If licensed in multiple scopes of practice, use the license for the type of disability you are certifying for.
- Do not fax or photocopy the form.
- Mail the completed form to the EDD in the pre-addressed envelope provided.
- Do not mail this form to the EDD if you have already submitted this claim online.

SAMPLE, this page for reference only



Claim for Disability Insurance (DI) Benefits

Health Insurance Portability and Accountability Act (HIPAA) Authorization

Claimant Social Security Number 0000000000

Claimant Name (First) (M) (Last) Sample Claimant

I authorize Geoff Booker

(Person/Organization providing the information) to furnish and disclose all my health information and to allow inspection of and provide copies of any medical, vocational rehabilitation, and billing records concerning my disability for which this claim is filed that are within their knowledge to the following employees of the California Employment Development Department (EDD): Disability Insurance Branch examiners, their direct supervisors/managers and any other EDD employee who may have a need to access this information in order to process my claim and/or determine eligibility for State Disability Insurance benefits.

I understand that EDD is not a health plan or health care provider, so the information released to EDD may no longer be protected by federal privacy regulations. (45 CFR Section 164.508(c)(2)(iii)). EDD may disclose information as authorized by the California Unemployment Insurance Code.

I agree that photocopies of this authorization shall be as valid as the original.

I understand I have the right to revoke this authorization by sending written notification stopping this authorization to EDD, DI Branch MIC 29, PO Box 826880, Sacramento, CA 94280. The authorization will stop on the date my request is received. I understand that the consequences for my revoking this authorization may result in denial of further State Disability Insurance benefits.

I understand that, unless revoked by me in writing, this authorization is valid for fifteen years from the date received by EDD or the effective date of the claim, whichever is later. I understand that I may not revoke this authorization to avoid prosecution or to prevent EDD's recovery of monies to which it is legally entitled.

I understand that I am signing this authorization voluntarily and that payment or eligibility for my benefits will be affected if I do not sign this authorization. The consequences for my refusal to sign this authorization may result in an incomplete claim form that cannot be processed for payment of State Disability Insurance benefits.

I understand I have the right to receive a copy of this authorization.

Claimant Signature (Do Not Print) Sample Claimant Date Signed 12252015

Claim for Disability Insurance (DI) Benefits (DE 2501)

Part A - Claimant's Statement, pages 7-10.

Page 7 – The Health Insurance Portability and Accountability (HIPAA) Authorization needs to be signed by the claimant.

Do not photocopy or fax this form.

SAMPLE, this page for reference only

Claim for Disability Insurance (DI) Benefits -
Physician/Practitioner's Certificate
PLEASE PRINT WITH BLACK INK.

PART B - PHYSICIAN/PRACTITIONER'S CERTIFICATE

B1. PATIENT'S SOCIAL SECURITY NUMBER: 0000000000 B2. PATIENT'S FILE NUMBER: 69-642-38

B3. IF YOU KNOW THE PATIENT'S ELECTRONIC RECEIPT NUMBER, ENTER IT HERE: R B4. PATIENT'S DATE OF BIRTH: 01011900

B5. PATIENT'S NAME (FIRST) (MI) (LAST): Sample Claimant

B6. PHYSICIAN/PRACTITIONER'S LICENSE NUMBER: 634-027930 B7. STATE OR COUNTRY (IF NOT U.S.A.) THE ISSUED LICENSE NUMBER ENTERED IN B6: STATE CA COUNTRY

B8. PHYSICIAN/PRACTITIONER LICENSE TYPE: MD B9. SPECIALTY (IF ANY):

B10. PHYSICIAN/PRACTITIONER'S NAME AS SHOWN ON LICENSE (FIRST) (MI) (LAST) SUFFIX: Geoff Booker

B11. PHYSICIAN/PRACTITIONER'S ADDRESS
MAILING ADDRESS, PO BOX OR NUMBER/STREET/SUITE: 269 Commerce
CITY STATE ZIP OR POSTAL CODE COUNTRY (IF NOT U.S.A.): Anywhere CA 72694
COUNTY HOSPITAL/GOVERNMENT FACILITY ADDRESS
FACILITY NAME (IF APPLICABLE):
FACILITY ADDRESS, NUMBER/STREET/SUITE:
CITY STATE ZIP OR POSTAL CODE COUNTRY (IF NOT U.S.A.):

B12. THIS PATIENT HAS BEEN UNDER MY CARE AND TREATMENT FOR THIS MEDICAL PROBLEM
FROM 12162015 TO CHECK HERE TO INDICATE YOU ARE STILL TREATING THE PATIENT
AT INTERVALS OF: DAILY WEEKLY MONTHLY AS NEEDED OTHER

B13. AT ANY TIME DURING YOUR ATTENDANCE FOR THIS MEDICAL PROBLEM, HAS THE PATIENT BEEN INCAPABLE OF PERFORMING HIS/HER REGULAR OR CUSTOMARY WORK?
 YES - ENTER DATE DISABILITY BEGAN 12162015 NO - SKIP TO B15
WAS THE DISABILITY CAUSED BY AN ACCIDENT OR TRAUMA? YES NO
IF YES, INDICATE THE DATE THE ACCIDENT OR TRAUMA OCCURRED:

B14. DATE YOU RELEASED OR ANTICIPATE RELEASING PATIENT TO RETURN TO HIS/HER REGULAR OR CUSTOMARY WORK
(UNKNOWN, INDEFINITE, ETC., NOT ACCEPTABLE):
 CHECK HERE TO INDICATE PATIENT'S DISABILITY IS PERMANENT AND YOU NEVER ANTICIPATE RELEASING PATIENT TO RETURN TO HIS/HER REGULAR OR CUSTOMARY WORK

B15. IF PATIENT IS NOW PREGNANT OR HAS BEEN PREGNANT, PLEASE CHECK THE APPROPRIATE BOX AND ENTER THE FOLLOWING:
ESTIMATED DELIVERY DATE: DATE PREGNANCY ENDED:
TYPE OF DELIVERY, IF PATIENT HAS DELIVERED: VAGINAL CESAREAN

Claim for Disability Insurance (DI)
Benefits (DE 2501)

Part B - Physician's/Practitioner's
Certificate, pages 11-13.

All appropriate information including
dates, diagnosis, and treatment codes
must be completed by the
physician/practitioner. The
physician/practitioner needs to sign
page 13.

Claim for Paid Family Leave (PFL) Benefits (DE 2501F)

Part A -Statement of Claimant, page 1.

Complete the information, including whether this is for a bonding or care claim. Make sure to sign and date the form.

Care Recipient Authorization for Disclosure of Personal-Health Information, page 2.

The person receiving care, or his/her authorized agent, must sign the bottom of this page.

SAMPLE, this page for reference only

EDD Employment Development Department
State of California

Claim for Paid Family Leave (PFL) Benefits

PART A - STATEMENT OF CLAIMANT (CARE OR BONDING PROVIDER)

A1. YOUR SOCIAL SECURITY NO. A2. YOUR DATE OF BIRTH A3. LANGUAGE YOU PREFER TO USE
 ENGLISH SPANISH OTHER (PRINT BELOW)

A4. YOUR LEGAL NAME FIRST NAME

A6. YOUR TELEPHONE NUMBER

A8. YOUR MAILING ADDRESS (TO RES.)
 ANY
 CITY

A5. NAME OF YOUR EMPLOYER

 CITY

A16. DATE YOU LAST WORKED
 M M D D Y Y Y Y

A14. WHY DID YOU OR WILL YOU BE CARE FOR?
 CARE FOR FAMILY MEMBER BOND WITH CHILD

A16. LEGAL NAME OF PERSON FOR WHOM YOU ARE PROVIDING CARE

A17. THE ABOVE-NAMED CARE OR BONDING PROVIDER IS:
 CHILD SPOUSE PARTNER

A18. IS ANY OTHER FAMILY MEMBER AVAILABLE TO PROVIDE CARE?
 NO YES

A20. DO YOU HAVE MORE THAN ONE EMPLOYER?
 NO YES

A21. AT ANY TIME DURING YOUR EMPLOYMENT, WERE YOU CONVICTED OF VIOLATING ANY FEDERAL, STATE, OR LOCAL LAWS?
 YES NO

A24. Declaration and Signature. By signing this form, you are certifying that the information provided is true and correct, and complete. If you are providing care for a child, you are certifying that you are the biological, adoptive, or foster parent of the child, or the child's legal guardian, and that you are at least 18 years old on the date of my signature.

Claimant's Signature
 *If your signature is made by mark, please print name and address.

SAMPLE, this page for reference only

CARE RECIPIENT'S AUTHORIZATION FOR DISCLOSURE OF PERSONAL-HEALTH INFORMATION

I authorize my physician or practitioner, as identified on Part D of this claim, to disclose my current personal-health information to my care provider, as identified on Part A of this claim, and to the California Employment Development Department (EDD).

I understand that such information includes a diagnosis and prognosis of my current condition, the date it commenced, and an estimation of the amount of care that I require from my care provider as a result of my current condition. I further understand that disclosure of my personal-health information may include my AIDS/HIV status, drug or alcohol addiction, or any other physical or mental condition.

I understand that EDD may disclose this information as authorized by the California Unemployment Insurance Code and that such re-disclosed information may no longer be protected. I agree that photocopies of the authorization form in conjunction with my signature on Page 3 in Item 6 of Part C shall be as valid as the original.

I understand that unless I inform EDD in writing at PO Box 989315, West Sacramento, CA 95798-9315, that I wish to revoke this authorization, it will be valid for 10 years from the date EDD receives it or the effective date of this claim, whichever is later. I understand that I have the right to receive a copy of an authorization form from EDD if I request one in writing.

I make this authorization to support my care provider's claim for Paid Family Leave benefits. I understand that I may not revoke my authorization to avoid prosecution or to prevent EDD's recovery of monies to which it is legally entitled.

WE CANNOT PROCESS THIS CLAIM UNLESS YOU SIGN BOTH THIS PAGE AND PAGE 3 IN ITEM C6 OF PART C.

Care recipient's name (Print your name)

Care recipient's signature (Sign your name)

Date signed _____

DE 2501F Rev. 4 (7-20) (INTRANET)

Page 2 of 4

SAMPLE, this page for reference only

PART B – BONDING CERTIFICATION (TO BE COMPLETED BY PERSON CLAIMING PFL BENEFITS TO BOND WITH A CHILD)			
B1. YOUR SOCIAL SECURITY NUMBER 0 0 0 0 0 0 0 0 0 0	B2. DATE OF FOSTER CARE OR ADOPTION PLACEMENT M M D D Y Y Y Y	B3. CHILD NAMED IN B8 IS MY BIOLOGICAL CHILD <input checked="" type="checkbox"/> FOSTER CHILD <input type="checkbox"/> ADOPTED CHILD <input type="checkbox"/> OTHER <input type="checkbox"/>	
B4. YOUR LEGAL LAST NAME (NEEDED IN CASE PAGES OF THIS CLAIM BECOME SEPARATED) C L A I M A N T	B5. CHILD'S SOCIAL SECURITY NUMBER (IF AVAILABLE)	B6. CHILD'S DATE OF BIRTH M M D D Y Y Y Y 1 2 0 1 2 0 1 5	B7. CHILD'S GENDER MALE <input type="checkbox"/> FEMALE <input checked="" type="checkbox"/>
B8. LEGAL NAME OF CHILD (FIRST, MIDDLE INITIAL, LAST) C O O K I E A C L A I M A N T			
B9. CHILD'S RESIDENCE ADDRESS (IF DIFFERENT FROM CLAIMANT'S) CITY STATE/PROV. ZIP OR POSTAL CODE COUNTRY (IF NOT U.S.A.)			
B10. AS EVIDENCE OF THE RELATIONSHIP IN B3, CHECK ONE OF THE FOLLOWING AND ATTACH A COPY OF THE DOCUMENT CHECKED. (DO NOT SEND ORIGINAL DOCUMENT. IT WILL NOT BE RETURNED.)			
<input checked="" type="checkbox"/> CHILD'S BIRTH CERTIFICATE		<input type="checkbox"/> ADOPTIVE PLACEMENT AGREEMENT, AD-907	
<input type="checkbox"/> DECLARATION OF PATERNITY, CS-909		<input type="checkbox"/> INDEPENDENT ADOPTION PLACEMENT AGREEMENT, AD-924	
<input type="checkbox"/> FOSTER CARE PLACEMENT RECORD, SOC-815		<input type="checkbox"/> OTHER	
B11. Declaration and Signature. By my signature on this bonding certification, I authorize the medical provider, adoption agency, adoption party(ies), or foster care placement agency to disclose to the Employment Development Department all facts concerning the birth, adoption, or foster care placement of the above-named child. I understand that willfully making a false statement or concealing a material fact in order to obtain payment of benefits is a violation of California law punishable by imprisonment or fine or both. I declare under penalty of perjury that the foregoing statement, including any accompanying statements or documents, is to the best of my knowledge and belief true, correct, and complete. I agree that photocopies of this authorization shall be as valid as the original, and I understand that authorizations contained in this claim statement are granted for a period of fifteen years from the date of my signature or the effective date of the claim, whichever is later.			
Original Signature of Bonding Claimant – RUBBER STAMP IS NOT ACCEPTABLE Sample Claimant		Date Signed (M M D D Y Y Y Y) 1 2 1 6 2 0 1 5	
PART C – STATEMENT OF CARE RECIPIENT (MAY BE COMPLETED BY CLAIMANT IF CARE RECIPIENT IS MENTALLY OR PHYSICALLY UNABLE TO DO SO. MUST BE SIGNED BY CARE RECIPIENT OR CARE RECIPIENT'S AUTHORIZED REPRESENTATIVE.)			
C1. RECIPIENT'S DATE OF BIRTH M M D D Y Y Y Y	C2. RECIPIENT'S TELEPHONE NUMBER	C3. RECIPIENT'S GENDER MALE <input type="checkbox"/> FEMALE <input type="checkbox"/>	
C4. LEGAL NAME OF CARE RECIPIENT (FIRST, MIDDLE INITIAL, LAST)			
C5. CARE RECIPIENT'S RESIDENCE ADDRESS CITY STATE/PROV. ZIP OR POSTAL CODE COUNTRY (IF NOT U.S.A.)			
C6. CONFIRMATION OF MEDICAL DISCLOSURE AUTHORIZATION. I have read and signed the Care Recipient's Authorization for Disclosure of Personal-Health Information on page 2 of this claim. I understand that by signing it I have agreed to all its provisions and terms. I further understand that copies of my signature below are as valid as the original.			
Care Recipient's Signature (DO NOT PRINT)		Date Signed (M M D D Y Y Y Y)	
C7. Authorized Representative signing on behalf of care recipient must complete the following: I, _____, represent the care or bonding recipient in this matter as authorized by <input type="checkbox"/> parental right <input type="checkbox"/> power of attorney (attach copy) <input type="checkbox"/> court order (attach copy) (For spouse or domestic partner, complete EDO.)			
Authorized Representative's Signature (DO NOT PRINT)		Date Signed (M M D D Y Y Y Y)	

Claim for Paid Family Leave (PFL) Benefits (DE 2501F)

Part B - Bonding Certification (bonding claims only) and Part C - Statement of Care Recipient (care claims only), page 3.

Part B – For bonding claims the claimant must complete all bonding information and sign the form.

Part C – For care claims the patient/care recipient or claimant must fill out the appropriate care information. The care recipient or their authorized representative must sign the form.

Claimant/patient will complete either Part B or Part C – but never both for one claim.

SAMPLE, this page for reference only

Medical certifications must be completed by a licensed physician or practitioner authorized to certify a patient's disability/serious health condition pursuant to California Unemployment Insurance Code Section 2708.

INSTRUCTIONS FOR COMPLETING THIS FORM:

Please complete the information in the spaces provided in UPPER CASE using black ink. Do not use special characters (-, /, '). If handwritten, print each letter or number in a separate box. Ignore the boxes provided if using a typewriter or printer.

PART D - PHYSICIAN/PRACTITIONER'S CERTIFICATION (DO NOT COMPLETE THIS PART IF YOU ARE BONDING WITH A CHILD.)			
D1. PFL CLAIMANT'S (CARE PROVIDER'S) SOCIAL SECURITY NUMBER		D2. PFL CLAIMANT'S NAME (FIRST MIDDLE INITIAL LAST)	
D3. PATIENT'S DATE OF BIRTH (M M D D Y Y Y Y)		D4. DOES YOUR PATIENT REQUIRE CARE BY THE CLAIMANT? (NO (IMP TO DTS) YES)	
D5. PATIENT'S NAME (FIRST MIDDLE INITIAL LAST)			
D6. DIAGNOSIS OR, IF NOT YET DETERMINED, A DETAILED STATEMENT OF SYMPTOMS			
D7. PRIMARY ICD CODE	D8. SECONDARY ICD CODES	D9. DATE PATIENT'S CONDITION COMMENCED (M M D D Y Y Y Y)	
D10. FIRST DATE CARE NEEDED (M M D D Y Y Y Y)	D11. DATE YOU EXPECT RECOVERY (M M D D Y Y Y Y) NEVER	D12. DATE YOU ESTIMATE PATIENT WILL NO LONGER REQUIRE CARE BY THE CLAIMANT (M M D D Y Y Y Y) PERMANENT	
D13. APPROXIMATELY HOW MANY TOTAL HOURS PER DAY WILL PATIENT REQUIRE CLAIMANT? (HOURS COMMENTS)			
D14. WOULD DISCLOSURE OF THIS CERTIFICATE TO YOUR PATIENT BE MEDICALLY OR PSYCHOLOGICALLY DETRIMENTAL? (NO YES)			
D15. PHYSICIAN/PRACTITIONER'S LICENSE NUMBER		D16. STATE OR COUNTRY PHYSICIAN/PRACTITIONER IS LICENSED	
D17. PHYSICIAN/PRACTITIONER'S NAME (FIRST MIDDLE INITIAL LAST)			
D18. PHYSICIAN/PRACTITIONER'S ADDRESS (POST OFFICE BOX IS NOT ACCEPTABLE AS THE SOLE ADDRESS)			
CITY		STATE/PROV.	ZIP OR POSTAL CODE COUNTRY (IF NOT U.S.A.)
D19. TYPE OF PHYSICIAN/PRACTITIONER		D20. SPECIALTY (IF ANY)	
D21. PHYSICIAN/PRACTITIONER'S Certification and Signature: I certify under penalty of perjury that this patient has a serious health condition and requires a care provider. I have performed a physical examination and/or treated the patient. I am authorized to certify a patient disability or serious health condition pursuant to California Unemployment Insurance Code Section 2708.			
Original Signature of Attending Physician/Practitioner - RUBBER STAMP IS NOT ACCEPTABLE		PHYSICIAN/PRACTITIONER'S PHONE NO.	Date Signed (M M D D Y Y Y Y)

Under sections 2116 and 2122 of the California Unemployment Insurance Code, it is a violation for any individual who, with intent to defraud, falsely certifies the medical condition of any person in order to obtain disability insurance benefits, whether for the maker or for any other person, and is punishable by imprisonment and/or a fine not exceeding \$20,000. Sections 1143 and 3305 require additional administrative penalties.

Claim for Paid Family Leave (PFL) Benefits (DE 2501F)

Part D – Physician/Practitioner’s Certification, page 4.

Care Claims:

You (the physician/practitioner) must complete all patient information for care claims, including dates and diagnosis codes and you must sign the bottom of the form.

You and your patient and the claimant caregiver should make sure all pages are completed and all signatures are obtained before the claim form is mailed back to the EDD for processing.

Visit www.edd.ca.gov/disability for more information about State Disability Insurance.

For help with SDI Online for physicians/practitioners,
call 1-855-342-3645

(Please do not give this number out to patients. This number is for physician/practitioners only. All other callers will be redirected.)

The EDD is an equal opportunity employer/program. Auxiliary aids and services are available upon request to individuals with disabilities. Requests for services, aids, and/or alternate formats need to be made by calling 1-866-490-8879 (voice), or through the California Relay Service at 711.