

SDI Online Tutorial:

Physician/Practitioner and

Physician/Practitioner Representative

Registration, Online Access Information, and Form

Submission

SDI Online Overview for Physicians/Practitioners

Physicians/practitioners and their representatives 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 physician/practitioner representative for an unlimited number of physicians/practitioners.

Physician/Practitioner Registration



State Disability Insurance

Disability Insurance and Paid Family Leave Benefits

The California State Disability Insurance (SDI) program provides short-term Disability Insurance (DI) and Paid Family Leave (PFL) wage replacement benefits to eligible workers who need time off work. You may be eligible for DI if you are unable to work due to non-work-related illness or injury, pregnancy, or childbirth. You may be eligible for PFL to care for a seriously ill family member or to bond with a new child. To file for benefits, visit [SDI Online](#).

To provide feedback about the SDI information available on the EDD website, take our [SDI Survey](#).

Disability Insurance

- About Disability Insurance
- DI Claim Process
- SDI Online
- Am I Eligible for DI Benefits?
- [More...](#)



Paid Family Leave

- About Paid Family Leave
- PFL Claim Process
- SDI Online
- Am I Eligible for PFL Benefits?
- [More...](#)



Employers and Self-Employed

- Eligibility
- Requirements
- Elective Coverage
- Workers' Compensation
- [More...](#)

Physicians/Practitioners

- Basics for Physicians/Practitioners
- Independent Medical Examiners
- Medical Certification
- Online Tutorials
- [More...](#)

Voluntary Plans

- Voluntary Plans
- Pre-Requisites for Becoming a Voluntary Plan Employer
- Legal Requirements
- Contributions Rates and Benefit Amounts
- [More...](#)

General Information

- FAQs
- Forms and Publications
- Paid Family Leave Market Research Report 2015
- PFL Community Partners
- Self-Service Options
- Contact SDI
- [More...](#)

To create an SDI Online account, visit www.edd.ca.gov/disability.

On the **State Disability Insurance** overview page, select any **SDI Online** link.

SDI Online

En español

The Employment Development Department (EDD) automated some key State Disability Insurance (SDI) services to better serve you with your Disability Insurance (DI) and Paid Family Leave (PFL) needs.

SDI Online is convenient and secure. The system reduces claim processing time, provides electronic confirmation of forms submitted online, decreases costs in paper and postage, and includes security safeguards to detect and manage fraud and abuse. A mobile-friendly version, [SDI Online Mobile](#) is available for your smartphone and tablet.

Log In or Register

If you have an existing account, select the appropriate login option. Before using SDI Online or SDI Online Mobile, you must register in SDI Online.

Log In

Log into Mobile

Register

Note: If you are experiencing trouble accessing SDI Online, visit [Troubleshooting Tips for Accessing SDI Online](#).

Disability Insurance Claimants

- [How to File a DI Claim in SDI Online](#)
- [Manage Your Claim with SDI Online](#)
- [Am I Eligible for DI?](#)
- [SDI Online Tutorials](#)
- [SDI Online Tips for Claimants](#)
- [SDI Online FAQs](#)

Paid Family Leave Claimants

- [How to File a PFL Claim in SDI Online](#)
- [Manage Your PFL Claim with SDI Online](#)
- [Am I Eligible for PFL?](#)
- [SDI Online Tutorials](#)
- [SDI Online Tips for Claimants](#)
- [SDI Online FAQs](#)

Select the **SDI Online Registration** link to register.

You will be directed to the **SDI Registration Instructions** page. Select **Continue to Physician/Practitioner Registration** and follow the instructions.

CA .GOV EDD Employment Development Department State of California Skip to main content Help | Login

Contact SDI

Online
By Location
By Phone
Telephone Numbers
Automated Info System

Security Check

*Indicates Required Field

Security Check



Try Another
Vision Impaired
Help

*Please type both words separated by a space below:

You do not have permission to access this website if you are using an automated program.

This Security Check allows us to:

Ensure Restricted Access to Registration
Automated programs known as "Bots" cannot read distorted text as well as humans. The Security Check helps prevent automated programs from blocking other users from registering for accounts with the EDD.

Provide an Audio Option for Visually Impaired Customers
An audio option allows visually impaired customers to hear a set of eight (8) digits that can be entered instead of the word challenge.

Next

On the **Security Check** page, type the text displayed and then select **Next**.

CA .GOV EDD Employment Development Department State of California Skip to main content Help | Login

Contact SDI

Online
By Location
By Phone
Telephone Numbers
Automated Info System

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.

I Do Not Agree I Agree

Read the Terms and Conditions and select **I Agree**.

Selecting **I Do Not Agree** prevents an account from being established.

Contact SDI

Online
By Location
By Phone
Telephone Numbers
Automated Info
System

Physician/Practitioner: Account Verification Information

***Indicates Required Field**

If you already have an account with SDI, [log in here](#).

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:

*Re-Type E-mail Address:

*Date of Birth: (MMDDYYYY)

*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:

*Physician/Practitioner License Number:

NPI Number:

*License Expiration Date: (MMDDYYYY)

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:

*ZIP Code:

*Phone Number: Ext: Check here if the phone number is international
(No dashes or spaces)

Back to Top | Contact EDD | Conditions of Use | Privacy Policy | Equal Opportunity Notice

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.

Contact SDI

Physician/Practitioner Representative: Setup Security Profile Information

- Online
- By Location
- By Phone
- Telephone Numbers
- Automated Info System

*Indicates Required Field

Account Information

Enter a Username and Password. Do not share your password with anyone.

*Username:
(must be 8 to 15 characters, no special characters)

*Password: (case sensitive)
(must be 8 to 12 characters long, including an uppercase letter, a lowercase letter, a number, and one of the following: ! # \$ % ^ & * () -)

*Re-Type Password: (case sensitive)

*Password Hint: (50 characters maximum, no special characters)

Choose your Security Questions and enter your answer to each question. This will be part of your Account Recovery Options.

*Question 1: Please select your question

*Answer to Question 1: (50 characters maximum, no special characters)

*Question 2: Please select your question

*Answer to Question 2: (50 characters maximum, no special characters)

*Question 3: Please select your question

*Answer to Question 3: (50 characters maximum, no special characters)

*Question 4: Please select your question

*Answer to Question 4: (50 characters maximum, no special characters)

*Choose your Personal Image and enter a Personal Image Caption for it. The image along with your image caption helps you know that you are at a valid EDD site and that it is safe to enter information. [Refresh to get a new set of personal images.](#)



*Personal Image Caption: (50 characters maximum, no special characters)

Next

Cancel

Complete the Account Information section by selecting a Username, Password, Personal Image, and Security Questions and entering your answers. Then select **Next**.

Be sure to make note of this information to ensure easy access when using SDI Online.

Physician/Practitioner: Personal Profile Information

*Indicates Required Field

Communication Preferences

Indicate below how you prefer to be notified. Some EDD forms are not available online and will be sent through the 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

Submit

Cancel

[Back to Top](#) | [Contact EDD](#) | [Conditions of Use](#) | [Privacy Policy](#) | [Equal Opportunity Notice](#)

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



Contact SDI

- Online
- By Location
- By Phone
- Telephone Numbers
- Automated Info System

Account Setup Confirmation

Successful Account Creation Notification

Your account has been created and your EDD Customer Account Number is 1234567890. A notification has been sent to you via e-mail. If you do not receive an email, please check your junk/spam folder. To ensure e-mails from the EDD appear in your inbox, add noreply@edd.ca.gov to your address book.

[Login](#)

A letter will be mailed to your address to confirm this account has been created. Be sure to make a note of your EDD Customer Account Number.

If you selected electronic communication, a notification will also be sent to you via e-mail.

Select **Login** to access your newly created account.

Access Physician/Practitioner Account

The screenshot shows the EDD website header with the logo and navigation menu. The main content area is titled 'SDI Online' and includes a 'Log In or Register' section. The 'Log In' button is highlighted with a red box. Below the buttons is a note about troubleshooting and two columns of links for claimants.

CA.gov State of California
Employment Development Department

Search

Home About EDD Find a Job File & Manage a Claim Employer Services EDD News

SDI Online

En español

The Employment Development Department (EDD) automated some key State Disability Insurance (SDI) services to better serve you with your Disability Insurance (DI) and Paid Family Leave (PFL) needs.

SDI Online is convenient and secure. The system reduces claim processing time, provides electronic confirmation of forms submitted online, decreases costs in paper and postage, and includes security safeguards to detect and manage fraud and abuse. A mobile-friendly version, [SDI Online Mobile](#) is available for your smartphone and tablet.

Log In or Register

If you have an existing account, select the appropriate login option. Before using SDI Online or SDI Online Mobile, you must register in SDI Online.

[Log In](#) [Log into Mobile](#) [Register](#)

Note: If you are experiencing trouble accessing SDI Online, visit [Troubleshooting Tips for Accessing SDI Online](#).

Disability Insurance Claimants

- [How to File a DI Claim in SDI Online](#)
- [Manage Your Claim with SDI Online](#)
- [Am I Eligible for DI?](#)
- [SDI Online Tutorials](#)
- [SDI Online Tips for Claimants](#)
- [SDI Online FAQs](#)

Paid Family Leave Claimants

- [How to File a PFL Claim in SDI Online](#)
- [Manage Your PFL Claim with SDI Online](#)
- [Am I Eligible for PFL?](#)
- [SDI Online Tutorials](#)
- [SDI Online Tips for Claimants](#)
- [SDI Online FAQs](#)

To access your account, visit www.edd.ca.gov/disability and select the **SDI Online** link.

On the **State Disability Insurance (SDI) Online** page, select **SDI Online Login**.

You will be directed to the **SDI Online Login** page where you will log in using your Username and Password.



Employment Development Department
 State of California

[Skip to main content](#)
[Help](#) | [Login](#)

Language: English

Contact SDI

- Online
- By Location
- By Phone
- Telephone Numbers
- Automated Info System

SDI Online Login

***Indicates Required Field**

*Username:

[Forgot username?](#)
[Register for a new online account](#)

SECURITY REMINDER
 Enter the username you provided during registration. We will ask you for your new password and display your personal image on the next screen.

On the **SDI Online Login** page, enter your Username and select **Submit**.



Employment Development Department
 State of California

[Skip to main content](#)
[Help](#) | [Login](#)

Contact SDI

- Online
- By Location
- By Phone
- Telephone Numbers
- Automated Info System

Confirm Your Personal Image and Log In

***Indicates Required Field**

Verify your personal image and enter your password.

Personal Image: 

Personal Image Caption: hat

Username: seamount2

*Password: (case sensitive)

[Forgot your personal image](#)
[Incorrect personal image showing?](#)
[Forgot password?](#)

SECURITY REMINDER
 Recognizing your Personal Image and Personal Image Caption helps you know that you are at a valid EDD web site, and that it is safe to enter your password.

If you do not recognize your personal image, do not enter your password.

Confirm the Personal Image, enter your Password, then select **Log In**.

MAIN MENU

- [Home](#)
- [Inbox](#)
- [Saved Drafts](#)
- [Manage My 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: (MMDDYYYY)

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 patients 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.

MAIN MENU

Home

- Inbox
- Saved Drafts
- Manage My Profile

*Indicates Required Field

License Information

Licensee Name

License Number

MAIN MENU

Message Center

- Home
- Inbox
- Saved Drafts
- Manage My Profile

Inbox

It is important to read all messages from EDD carefully. Select the subject hyperlink below to view the message.

No Results Found

MAIN MENU

Saved Drafts

- Home
- Inbox
- Saved Drafts
- Manage My Profile

Saved Drafts

To open and complete a form that you saved, select the Form Name. Saved drafts are stored for a limited number of days and will be automatically deleted on the date indicated. To delete a draft immediately, select the Delete action.

No Results Found

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

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

Saved 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

MAIN MENU

- Home
- Inbox
- ~~Saved Drafts~~
- Manage My Profile**

Home

*Indicates Required Field

License Information

Licensee Name

John Feelgood

License Number

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: (MMDDYYYY)

To add a treatment address, select **Manage My Profile** under the **Main Menu** on the **Home** page.

MAIN MENU

- Home
- Inbox
- Saved Drafts
- Manage My Profile

PAGE MENU

- Change Security Questions
- Change Password
- Change Personal Image
- Manage Treatment Address**
- Manage Medical Representative

Physician/Practitioner Update Personal Profile Information

Physician/ Practitioner Information

*Indicates Required Field

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: 05-31-2016

Address: 123 Main Street Ste 1
Anytown, CA 95148

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

I do not want to receive notifications. I will be reviewing the items in my message center regularly

Add

Save **Cancel**

You will be directed to the **Physician/Practitioner Update Personal Profile Information** page.

- Select **Manage Treatment Address** from the Page Menu.
- You can add a treatment address by selecting the **Add** button.



MAIN MENU

- Home
- Inbox
- Saved Drafts
- Manage My Profile

Add Modify Treatment Address

*Indicates Required Field

Add/Modify Treatment Address

US International

*Address Line 1:

Address Line 2:

*City:

*State: CA

*ZIP Code:

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

Save

Cancel

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 at which you practice.

MAIN MENU[Home](#)
[Inbox](#)
[Saved Drafts](#)
[Manage My Profile](#)**PAGE MENU**[Change Security Questions](#)
[Change Password](#)
[Change Personal Image](#)
[Manage Treatment Address](#)
[Manage Medical Representative](#)

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 St Anytown, CA 95814 United States	916-444-5555	Modify Delete

[Add](#)

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

MAIN MENU

- Home
- Inbox
- Saved Drafts
- Manage My 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: (MMDDYYYY)

Back to Top | Contact EDD | Conditions of Use | Privacy Policy | Equal Opportunity Notice

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 **Manage My Profile** from the **Main Menu**.

Select **Manage Medical Representative** from the **Page Menu**.

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

MAIN MENU

- Home
- Inbox
- Saved Drafts
- Manage My Profile

PAGE MENU

- Change Security Questions
- Change Password
- Change Personal Image
- Manage Treatment
- Address
- Manage Medical Representative

Physician/Practitioner Update Personal Profile Information

***Indicates Required Field**

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 n
License Type: Physician or Surgeon (MD)
Physician/Practitioner License Number: CA00000
License Expiration Date: 05-31-2016
Address: 123 Main St Ste 1
Anytown, CA 95814

MAIN MENU

- Home
- Inbox
- Saved Drafts
- Manage My Profile

PAGE MENU

- Change Security Questions
- Change Password
- Change Personal Image
- Manage Treatment
- Address
- 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

Save Cancel

MAIN MENU

- Home
- Inbox
- Saved Drafts
- Manage My Profile

PAGE MENU

- Change Security Questions
- Change Password
- Change Personal Image
- Manage Treatment Address
- Manage Medical Representative

Add Modify Medical Representative

***Indicates Required Field**

Add Representative

*First Name:

Middle Name:
(if the medical representative has no middle name, leave blank)

*Last Name:

Suffix:
(if the medical representative has no suffix, leave blank)

*Last 4 Digits of Social Security Number:

*E-mail Address:

*Re-Type E-mail Address:

*Date of Birth: (MMDDYYYY)

*Treatment Address:

*Account Status:

[Back to Top](#) | [Contact EDD](#) | [Conditions of Use](#) | [Privacy Policy](#) | [Equal Opportunity Notice](#)

Complete the required fields and select a treatment address. Then select **Save**.

MAIN MENU

Home

Inbox

Saved Drafts

Manage My Profile

PAGE MENU

Change Security Questions

Change Password

Change Personal Image

Manage Treatment Address

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.

Name	Last 4 Digits of Social Security Number	E-mail Address	Date of Birth	Treatment Address	Account Status	Action
Jane Doe	1234	Jane@email.com	01-01-1950	123 Main St Anytown CA 95814	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 Physician/Practitioner Representative Registration

▶ State Disability Insurance

Disability Insurance and Paid Family Leave Benefits

The California State Disability Insurance (SDI) program provides short-term Disability Insurance (DI) and Paid Family Leave (PFL) wage replacement benefits to eligible workers who need time off work. You may be eligible for DI if you are unable to work due to non-work-related illness or injury, pregnancy, or childbirth. You may be eligible for PFL to care for a seriously ill family member or to bond with a new child. To file for benefits, visit [SDI Online](#).

To provide feedback about the SDI information available on the EDD website, take our [SDI Survey](#).

Disability Insurance

- About Disability Insurance
- DI Claim Process
- ▶ [SDI Online](#)
- Am I Eligible for DI Benefits?
- [More...](#)

Paid Family Leave

- About Paid Family Leave
- PFL Claim Process
- ▶ [SDI Online](#)
- Am I Eligible for PFL Benefits?
- [More...](#)

Employers and Self-Employed

- Eligibility
- Requirements
- Elective Coverage
- Workers' Compensation
- [More...](#)

Physicians/Practitioners

- Basics for Physicians/Practitioners
- Independent Medical Examiners
- Medical Certification
- Online Tutorials
- [More...](#)

Voluntary Plans

- Voluntary Plans
- Pre-Requisites for Becoming a Voluntary Plan Employer
- Legal Requirements
- Contributions Rates and Benefit Amounts
- [More...](#)

General Information

- FAQs
- Forms and Publications
- Paid Family Leave Market Research Report 2015
- PFL Community Partners
- Self-Service Options
- Contact SDI
- [More...](#)

To create an SDI Online account, visit www.edd.ca.gov/disability.

On the **State Disability Insurance** overview page, select any **SDI Online** link.

SDI Online

En español

The Employment Development Department (EDD) automated some key State Disability Insurance (SDI) services to better serve you with your Disability Insurance (DI) and Paid Family Leave (PFL) needs.

SDI Online is convenient and secure. The system reduces claim processing time, provides electronic confirmation of forms submitted online, decreases costs in paper and postage, and includes security safeguards to detect and manage fraud and abuse. A mobile-friendly version, [SDI Online Mobile](#) is available for your smartphone and tablet.

Log In or Register

If you have an existing account, select the appropriate login option. Before using SDI Online or SDI Online Mobile, you must register in SDI Online.

Log In

Log into Mobile

Register

Note: If you are experiencing trouble accessing SDI Online, visit [Troubleshooting Tips for Accessing SDI Online](#).

Disability Insurance Claimants

- [How to File a DI Claim in SDI Online](#)
- [Manage Your Claim with SDI Online](#)
- [Am I Eligible for DI?](#)
- [SDI Online Tutorials](#)
- [SDI Online Tips for Claimants](#)
- [SDI Online FAQs](#)

Paid Family Leave Claimants

- [How to File a PFL Claim in SDI Online](#)
- [Manage Your PFL Claim with SDI Online](#)
- [Am I Eligible for PFL?](#)
- [SDI Online Tutorials](#)
- [SDI Online Tips for Claimants](#)
- [SDI Online FAQs](#)

Select the **SDI Online Registration** link to register.

You will be directed to the **SDI Registration Instructions** page. Select **Continue to Physician/Practitioner Representative Registration** and follow the instructions.

Contact SDI

Online
By Location
By Phone
Telephone Numbers
Automated Info System

Physician/Practitioner Representative: Account Verification Information

***Indicates Required Field**

If you already have an account with SDI, [log in here](#).

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:

*Re-Type E-mail Address:

*Date of Birth: (MMDDYYYY)

*Last four digits of Social Security Number:

[Back to Top](#) | [Contact EDD](#) | [Conditions of Use](#) | [Privacy Policy](#) | [Equal Opportunity Notice](#)

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**.

Contact SDI

Online
By Location
By Phone
Telephone Numbers
Automated Info System

Physician/Practitioner Representative: Setup Security Profile Information

***Indicates Required Field**

Account Information

Enter a Username and Password. Do not share your password with anyone.

*Username: (must be 8 to 15 characters, no special characters)

*Password: (case sensitive)
(must be 8 to 12 characters long, including an uppercase letter, a lowercase letter, a number, and one of the following: ! # \$ % ^ & * () -)

*Re-Type Password: (case sensitive)

*Password Hint: (50 characters maximum, no special characters)

Choose your Security Questions and enter your answer to each question. This will be part of your Account Recovery Options.

*Question 1:

*Answer to Question 1: (50 characters maximum, no special characters)

*Question 2:

*Answer to Question 2: (50 characters maximum, no special characters)

*Question 3:

*Answer to Question 3: (50 characters maximum, no special characters)

*Question 4:

*Answer to Question 4: (50 characters maximum, no special characters)

*Choose your Personal Image and enter a Personal Image Caption for it. The image along with your image caption helps you know that you are at a valid EDD site and that it is safe to enter information. [Refresh to get a new set of personal images.](#)

*Personal Image Caption: (50 characters maximum, no special characters)

Next **Cancel**

[Back to Top](#) | [Contact EDD](#) | [Conditions of Use](#) | [Privacy Policy](#) | [Equal Opportunity Notice](#)

Complete the **Account Information** section by selecting a Username, Password, Personal Image, and Security Questions. Then select **Next**.

Be sure to make note of this information to ensure easy access when using SDI Online.

Contact SDI	Physician/Practitioner Representative: Personal Profile Information
Online	
By Location	
By Phone	
Telephone Numbers	
Automated Info System	
	*Indicates Required Field
	Physician/Practitioner Representative Information
	Treatment Address: 123 Main St Anytown, CA 95814 United States
	*Phone Number: <input type="text"/> Ext: <input type="text"/> <input type="checkbox"/> Check here if the phone number is international (No dashes or spaces)
	Communication Preferences
	Indicate below how you prefer to be notified. Some EDD forms are not available online and will be sent through the US Postal Service.
	*Preferred Communication: <input checked="" type="radio"/> I prefer to be notified by e-mail. <input type="radio"/> I prefer to be notified by paper mail <input type="radio"/> I do not want to receive notifications. I will be reviewing the items in my message center regularly
	<input type="button" value="Submit"/> <input type="button" value="Cancel"/>
	Back to Top Contact EDD Conditions of Use Privacy Policy Equal Opportunity Notice

Verify the Treatment Address, enter the Phone Number, and select your preferred method of communication.

Select **Submit**.

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

Contact SDI

Account Setup Confirmation

Online
By Location
By Phone
Telephone Numbers
Automated Info System

Successful Account Creation Notification

Your account has been created and a notification has been sent to you via e-mail. If you do not receive an email, please check your junk/spam folder. To ensure e-mails from the EDD appear in your inbox, add noreply@edd.ca.gov to your address book.

[Login](#)

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 e-mail.

Select **Login** to access your newly created account.

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

MAIN MENU

- Home
- Inbox
- Saved Drafts
- Manage My 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: (MMDDYYYY)

Last 4 digits of SSN

Physicians/Practitioners

On the **Home** page, under the **Search** section, there are two ways to begin searching 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.



MAIN MENU

- Home
- Inbox
- Saved Drafts
- Manage My Profile

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	0	0	0

Physician/Practitioner Representatives

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**.

MAIN MENU

- Home
- Inbox
- Saved Drafts
- Manage My 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: (MMDDYYYY)

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

Receipt Number	Patient/PFL Name	Date Disability Began	Action
R100000000291737	Oliver October	10-02-2014	Submit Physician/Practitioner Certificate

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

No Results Found

Back to Top | Contact EDD | Conditions of Use | Privacy Policy | Equal Opportunity Notice

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.

MAIN MENU

- Home
- Inbox
- Saved Drafts
- Manage My 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 \(DE 2501\)](#)

Next **Cancel**

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

Select **Next** to complete the certificate.

MAIN MENU

- Home
- Inbox
- Saved Drafts
- Manage My Profile

Treatment Address

1 → 2 → 3 → 4
 Treatment Address Patient Information Claim Information/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
123 Main St Anytown, CA 95814 United States	Select

Previous **Not Found** **Cancel**

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

You are currently on Step 2 Patient Information

*Indicates Required Field

Section 1 - Patient Information

Patient's Name: Oliver October

Receipt Number: R100000000291737

Social Security Number:

Date of Birth: (MMDDYYYY)

File Number:

Section 2A - Physician/Practitioner Information

Name: John Feelgood

Treatment Address: 123 Main St
Anytown, CA 95814
United States

License Number CA00000

State of Licensure: CA

Country of Licensure: United States

*Phone Number: Ext: Check here if the phone number is international
(No dashes or spaces)

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: (MMDDYYYY)

To: (MMDDYYYY)

*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: (MMDDYYYY)

*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

Previous

Next

Save as Draft

Cancel

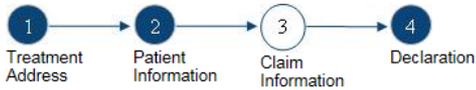
[Back to Top](#) | [Contact EDD](#) | [Conditions of Use](#) | [Privacy Policy](#) | [Equal Opportunity Notice](#)

Complete the **Patient Information** section and select **Next**.

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

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

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



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)

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:

*Diagnosis Code Version:

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

ICD Diagnosis Code:

Diagnosis Code Version:

ICD Diagnosis Code:

Diagnosis Code Version:

ICD Diagnosis Code:

Diagnosis Code Version:

*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)

Patient is still hospitalized? Yes No

Check here if the patient is deceased:

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

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.

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

Type: Date: (MMDDYYYY)

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

ICD Procedure Code: 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: (MMDDYYYY)

*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): (MMDDYYYY)

*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: (MMDDYYYY) Pregnancy End Date (if applicable): (MMDDYYYY)

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:

[Previous](#) [Next](#) [Save as Draft](#) [Cancel](#)

[Back to Top](#) | [Contact EDD](#) | [Conditions of Use](#) | [Privacy Policy](#) | [Equal Opportunity Notice](#)

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**.

MAIN MENU

- Home
- Inbox
- Saved Drafts
- Manage My Profile

ICD Code Summary

1 → 2 → 3 → 4
Treatment Address Patient Information Claim Information Declaration

You are currently on Step 3 Claim Information

Section 4B - ICD Code Summary

Type	ICD Code	Version	Diagnosis	Action
Primary Diagnosis Code	222.2	ICD-9	BENIGN NEOPLASM OF PROSTATE	Delete

[Previous](#) [Next](#) [Save as Draft](#) [Cancel](#)

[Back to Top](#) | [Contact EDD](#) | [Conditions of Use](#) | [Privacy Policy](#) | [Equal Opportunity Notice](#)

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.

MAIN MENU

- Home
- Inbox
- Saved Drafts
- Manage My Profile

Certification

1 → 2 → 3 → 4
 Treatment Address Patient Information Claim Information Declaration

You are currently on Step 4 Declaration

Section 7 - Certification

All Persons Authorized to Certify:

- All Physicians (Medical or Osteopathic Physician and Surgeon, Chiropractor, Dentist, Podiatrist, Optometrist, Designated Psychologist): I certify under penalty of perjury that the patient is unable to perform his/her regular or customary work because of the disability condition(s) listed above and I have treated the patient within my scope of practice.
- Nurse Practitioner: I certify under penalty of perjury that the patient is unable to perform his/her regular or customary work because of the disability condition(s) listed above and I have treated the patient within my scope of practice. If for a condition other than a normal pregnancy or delivery, I certify that I have performed a physical examination and have collaborated with a physician and surgeon.
- Registrar of a county hospital in California or medical officer of US Government medical facility: I certify under penalty of perjury that the patient is unable to perform his/her regular or customary work because of the disability condition(s) listed above and these conditions are shown by the patient's hospital chart.
- Other

Title of the person if not covered above (must be able to legally certify to a disability):

~~To view 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 \(DE 2501\)](#)

[Back to Top](#) | [Contact EDD](#) | [Conditions of Use](#) | [Privacy Policy](#) | [Equal Opportunity Notice](#)

Once the form is completed, select the box in the **Certification** section that best describes your role 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.

Note: physician/practitioner representatives submitting the DE 2501B on behalf of the physician/practitioner should select **All Physicians**.

MAIN MENU

- Home
- Inbox
- Saved Drafts
- Manage My Profile

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: [R10000000291738](#)

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 Supplementary Certificate
for Continued Benefits,
DE 2525XX

MAIN MENU

- Home
- Inbox
- Saved Drafts
- Manage My 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: (MMDDYYYY)

Search Results

Claim ID	Patient/PFL Name	Date of Birth	Claim Effective Date	Claim Type
D11000021843	Jane Doe	10-20-1975	12-15-2012	Disability Insurance

On the **Home** page, to submit a DE 2525XX – Supplementary 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.

Then select the **Claim ID** link.

MAIN MENU
Home
Inbox
Saved Drafts
Manage My Profile

Claim Summary

Claim Summary
Claimant Name: **Jane Doe** Claim ID: DI-1000-021-843
Claim Effective Date: 12-15-2012

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

[Back to Top](#) | [Contact EDD](#) | [Conditions of Use](#) | [Privacy Policy](#) | [Equal Opportunity Notice](#)

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

MAIN MENU
Home
Inbox
Saved Drafts
Manage My Profile

Physician/Practitioner Supplementary Certificate (Part 1)

***Indicates Required Field**

MAIN MENU
Home
Inbox
Saved Drafts
Manage My 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: (MMDDYYYY)

Date of Discharge: (MMDDYYYY)

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: (MMDDYYYY)

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

ICD Procedure Code: <input type="text"/>	Procedure Code Version: <input type="text" value="Select"/>
ICD Procedure Code: <input type="text"/>	Procedure Code Version: <input type="text" value="Select"/>
ICD Procedure Code: <input type="text"/>	Procedure Code Version: <input type="text" value="Select"/>
ICD Procedure Code: <input type="text"/>	Procedure Code Version: <input type="text" value="Select"/>

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

CPT Code: <input type="text"/>	CPT Code: <input type="text"/>
CPT Code: <input type="text"/>	CPT Code: <input type="text"/>

Present estimated date patient will be able to perform 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.

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

Previous **Next** **Save as Draft** **Cancel**

Complete the **Physician/Practitioner Supplementary Certificate** parts and select **Next**.

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

MAIN MENU

- Home
- Inbox
- Saved Drafts
- Manage My Profile

Submit Form

Section 5 - Certification

Submitted by John Feelgood

All Physicians (Medical or Osteopathic Physician and Surgeon, Chiropractor, Dentist, Podiatrist, Optometrist, Psychologist)

I certify under penalty of perjury that the patient is unable to perform his/her regular or customary work because of the disabling condition(s) listed above and I have treated the patient within my scope of practice.

Nurse Practitioner

I certify under penalty of perjury that the patient is unable to perform his/her regular or customary work because of the disabling condition(s) listed above and I have treated the patient within my scope of practice. If for a condition other than a normal pregnancy or delivery, I certify that I have performed a physical examination and have collaborated with a physician and surgeon.

Registrar of a County Hospital in California or Medical Officer of a US Government Medical Facility

I certify under penalty of perjury that the patient is unable to perform his/her regular or customary work because of the disabling condition(s) listed above and these conditions are shown by the patient's hospital chart.

Other

Title of person if not covered above (must be able to legally certify to a disability):

[Previous](#) [Submit](#) [Save as Draft](#) [Cancel](#)

[Back to Top](#) | [Contact EDD](#) | [Conditions of Use](#) | [Privacy Policy](#) | [Equal Opportunity Notice](#)

Once the form is completed, select the box in the **Certification** section that best describes your role 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.

Note: physician/practitioner representatives submitting the DE 2525XX on behalf of the physician/practitioner should select the **All Physicians** box.

MAIN MENU

- Home
- Inbox
- Saved Drafts
- Manage My Profile

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: [R10000000291751](#)

[Back to Top](#) | [Contact EDD](#) | [Conditions of Use](#) | [Privacy Policy](#) | [Equal Opportunity Notice](#)

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 DE 2501 F
PFL Care Claim

CA .GOV EDD Employment Development Department State of California (IVAN906) Help | Logout

Home

*Indicates Required Field

License Information

Licensee Name	License Number
John Feelgood	CA12345

Message Center

Inbox [New: 0, Total: 0]
Saved Drafts [Total: 1]

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 R10000000012345
*Patient/PFL Last Name: Doe
Date of Birth: (MMDDYYYY)

Search Cancel

Search Results

Receipt Number	Patient/PFL Name	Date of Birth	Action
R10000000012345	Jane Doe	04-18-1979	Submit Physician/Practitioner Certificate

Back to Top | Contact EDD | Conditions of Use | Privacy Policy | Equal Opportunity Notice

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.

MAIN MENU

Home
Inbox
Saved Drafts
Manage My 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: **Johnny Johnson**
Claimant Social Security Number: XXX-XX-1222

Patient (Care Recipient) Name: Nag N Spouse
Patient Date of Birth: 02-14-1971

*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

Next

Cancel

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.

MAIN MENU

- Home
- Inbox
- Saved Drafts
- Manage My Profile

Treatment Address



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
11000 Main St Palo Alto, CA 94301-3419 United States	Select
800 D St Sacramento, CA 95814-0716 United States	Select
800 D St Sacramento, CA 95814-0716 United States	Select

[Previous](#)[Cancel](#)

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

MAIN MENU

- Home
- Inbox
- Saved Drafts
- Manage My Profile

Initial Questions



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 State of Licensure: CA
Palo Alto, CA 94301-3419
United States

*Phone Number: Ext: Check here if the phone number is international
(No dashes or spaces)

Type of Physician/Practitioner: Physician or Surgeon (MD)
Specialty (if any):

Care Required Information

Claimant (Care Provider) Name: John Johnson
Claimant Social Security Number: XXX-XX-1222

Patient (Care Recipient) Name: Sony Kittu
Patient Date of Birth: 05-06-1982

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

[Previous](#)

[Next](#)

[Save as Draft](#)

[Cancel](#)

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

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

MAIN MENU

- Home
- Inbox
- Saved Drafts
- Manage My Profile

Medical Information

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: (MMDDYYYY)

*First date care needed: (MMDDYYYY)

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

Permanent Care Required

Date you expect recovery: (MMDDYYYY)

Never

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

*Hours:

Comments:

[Previous](#)

[Next](#)

[Save as Draft](#)

[Cancel](#)

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

If the patient's disability is diagnosed as permanent, select the **Permanent Care Required** box.

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

MAIN MENU

- Home
- Inbox
- Saved Drafts
- Manage My Profile

Certification

You are currently on Step 4 Certification

***Indicates Required Field**

Detrimental Medical

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

Certification

* As a Physician or Nurse Practitioner: I certify under penalty of perjury that, I have treated this patient within the scope of my practice and that the patient has a serious health condition that warrants the care of a care provider and that this Doctor's Certificate truly describes the patient's condition, the need for care and the estimated duration for which care is needed. If I am a Nurse Practitioner certifying a condition other than normal pregnancy or delivery, I additionally certify I have performed a physical examination and have collaborated with a physician and surgeon. If I am a Registrar of a County Hospital in California or a medical officer of a US government medical facility, I certify that the patient's serious health condition is shown in the patient's hospital chart.

To review the information you have entered, right click on the hyperlink and select "Open in New Window." Then select Save.

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

[Previous](#)

Submit

Save as Draft

Cancel

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.

MAIN MENU

[Home](#)
[Inbox](#)
[Saved Drafts](#)
[Manage My Profile](#)

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: [R10000000012345](#)

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

Disability Insurance (DE 2501)

Paid Family Leave (DE 2501F)

Health Insurance Portability and Accountability Act (HIPAA) Authorization

Claimant Social Security Number

Claimant Name (First) (MI) (Last)

I authorize

(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) Date Signed
M M D D Y Y Y Y

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

The Optical Character Recognition (OCR) version of paper form, DE 2501, for DI benefits is scanned and interfaces with SDI Online.

Part A pages 1-4:
Claimant's Statement

Do not photocopy or fax this form.

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

EDD Employment Development Department
State of California

Claim for Paid Family Leave (PFL) Benefits

2501F07141

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

A1. YOUR SOCIAL SECURITY NO. 1 2 3 4 5 6 7 8 9
 A2. YOUR DATE OF BIRTH 0 5 2 1 1 9 5 9
 A3. LANGUAGE YOU PREFER TO USE
 ENGLISH SPANISH OTHER (PRINT BELOW)

A4. YOUR LEGAL NAME
 FIRST NAME JANE
 LAST NAME D JONES
 A5. YOUR GENDER
 MALE FEMALE

A6. YOUR TELEPHONE NUMBER 9 1 6 5 5 5 1 2 1 2
 A7. OTHER LAST NAMES, IF ANY, UNDER WHICH YOU HAVE WORKED

A8. YOUR MAILING ADDRESS (TO RECEIVE MAIL AT A PRIVATE CITY)
 3 2 1 S P R I N G S
 ANYTOWN

A9. NAME OF YOUR EMPLOYER
 A B C C O R P O R A T E
 CITY
 ANYTOWN

A10. DATE YOU LAST WORKED 0 9 1 0 2 0 1 4
 A11. DATE YOU PFL CLAIM 0 9 2 0

A14. WHY DID YOU OR WILL YOU REDUCE YOUR WORK?
 CARE FOR BOND WITH
 FAMILY MEMBER CHILD OTHER (EXPLAIN)

A16. LEGAL NAME OF PERSON FOR WHOM YOU ARE PROVIDING CARE
 M A R Y

A17. THE ABOVE-NAMED CARE OR BONDING RECIPIENT'S STATUS
 REGISTERED DOMESTIC PARTNER PARTNER CHILD SPOUSE OTHER

A18. IS ANY OTHER FAMILY MEMBER READY, WILLING AND AVAILABLE TO PROVIDE CARE FOR THE SAME CLAIMANT?
 NO YES

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

A21. IS YOUR CURRENT EMPLOYER DURING YOUR PFL LEAVE?
 YES NO

A22. AT ANY TIME DURING YOUR PFL LEAVE, WERE YOU CONVICTED OF VIOLATING A LAW OR ORDER?

A24. Declaration and Signature. By my signature on this form, I authorize EDD to disclose my 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 P.O. 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.

Claimant's Signature (DO NOT PRINT)
 Jane D. Jones

*If your signature is made by mark (X), it must be attested by a witness.

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 P.O. 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.

MARY J. SMITH

Care recipient's name (Print your name)

Mary J. Smith

Care recipient's signature (Sign your name)

Sept. 23, 2014

Date signed

Page 1:
Claimant's Statement

Page 2:
Care Recipient's Authorization

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 for Disability Insurance (DE 2501)
 - Page D for Paid Family Leave (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.

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)

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.