



SDI ONLINE TUTORIAL

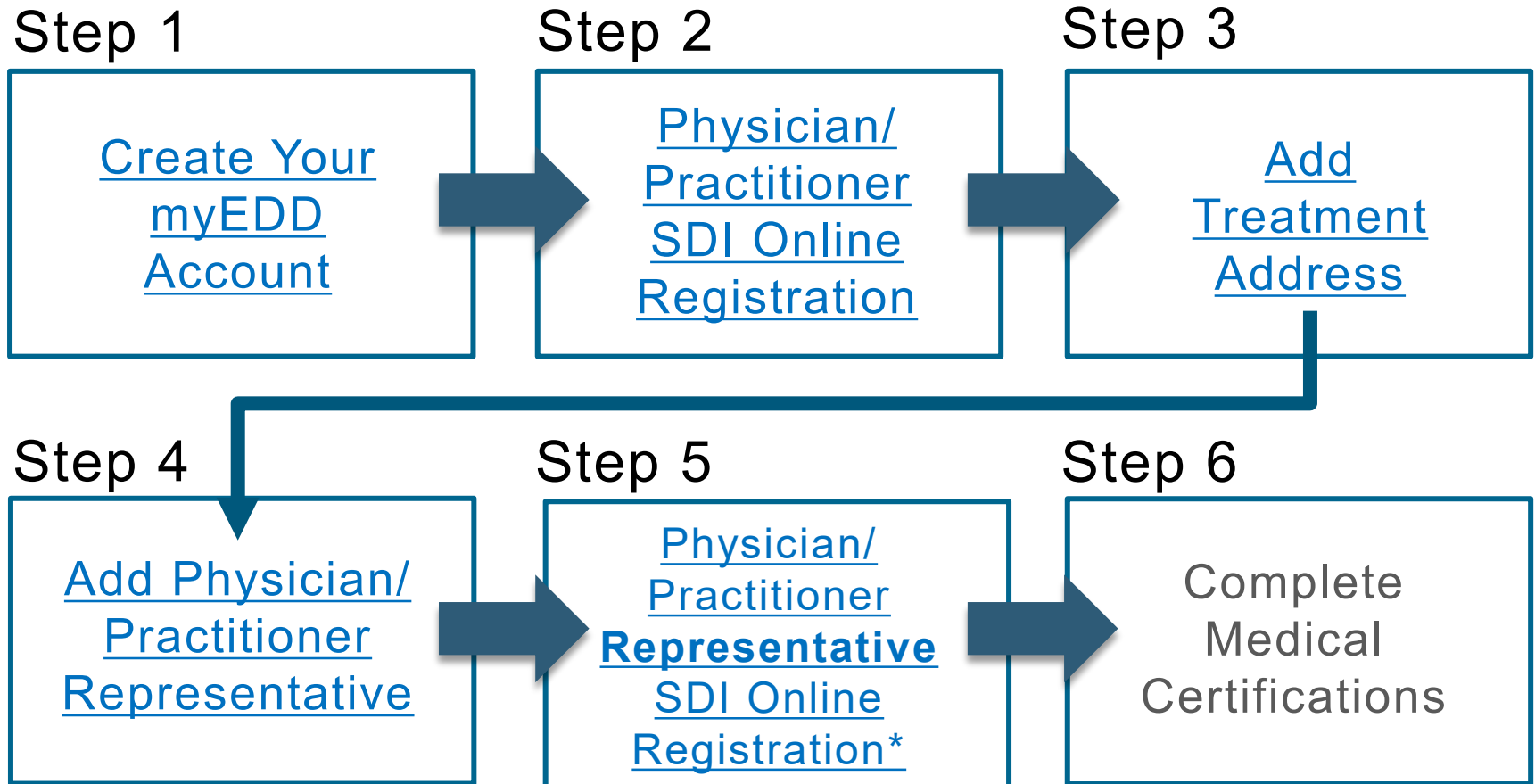
Physician/practitioner and Representative Registration, Online Access, and Forms Submission

Physicians/practitioners can use SDI Online to:

- Complete medical certifications for disability and paid family leave benefits.
- Assign medical representatives to complete medical certifications for benefits on behalf of the physician/practitioner.
 - A medical representative can create an account after the physician/practitioner has added them to their SDI Online profile.
 - A physician/practitioner may have an unlimited number of authorized medical representatives.
 - An individual can be an authorized medical representative for an unlimited number of physicians or practitioners.
- Complete our electronic requests for additional medical information.
- Update contact information.



Steps to Register an Authorized Representative:



*The authorized medical **representative** must also complete Step 1.

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Create Your myEDD Account

Learn more about how to create your myEDD account.



[Get Started](#)

What is myEDD?

To access Employment Development Department (EDD) benefits services you must complete a one-time registration in myEDD.

myEDD uses a single login to access:

- Unemployment benefits
- Disability benefits
- Paid Family Leave benefits
- Benefit Overpayments

We offer [step-by-step instructions](#) on how to create a new myEDD account.

If you already created a myEDD account, you may skip to:

- [Register as a Physician/Practitioner in SDI Online](#)
- [Register as a Medical Representative in SDI Online](#)

Create Your myEDD Account

1. Visit [myEDD](#) to create your account.
2. Select **Create Account**. To view the screens in Spanish, select **Español**.
3. Enter a company email that is used only by you.
4. Set up a password that is 10 or more characters. The password is case sensitive and must contain:
 - Uppercase and lowercase letters
 - Numbers
 - Symbols such as !@#\$
5. Select your preferred language, accept our terms and conditions, and select **Submit**.
6. Next, check your email to confirm your account. Select **Confirm Email** within 48 hours or you will need to start over.
7. Login to your myEDD account. When you log in for the first time, we will email you a verification code to verify your identity. Select, **Send Email**.

Create Your myEDD Account

8. Enter the verification code and select **Submit**. This code expires in 5 minutes. If you do not receive the verification code email, check your junk or spam folder or **select resend the email**.

9. Next, set up your security question. Select a question, enter the answer, and select **Continue** to save.

10. Now you can select your Login Verification method. You can receive the verification code by text message or phone call. To continue using email, select **Use my email instead**.

11. Enter your phone number then select **Text Code** or **Call My Phone**. Then enter the verification code. This code expires in 5 minutes. A screen will let you know you have successfully set up your login verification method.

12. Select **myEDD Home**, then select **SDI Online**. On the next screen, select the SDI Online registration account type.

Use myEDD to access SDI Online and submit disability or paid family leave medical certifications.



Register as a Physician/Practitioner in SDI Online

Learn more about how
physician/practitioners register in SDI
Online.



Get Started

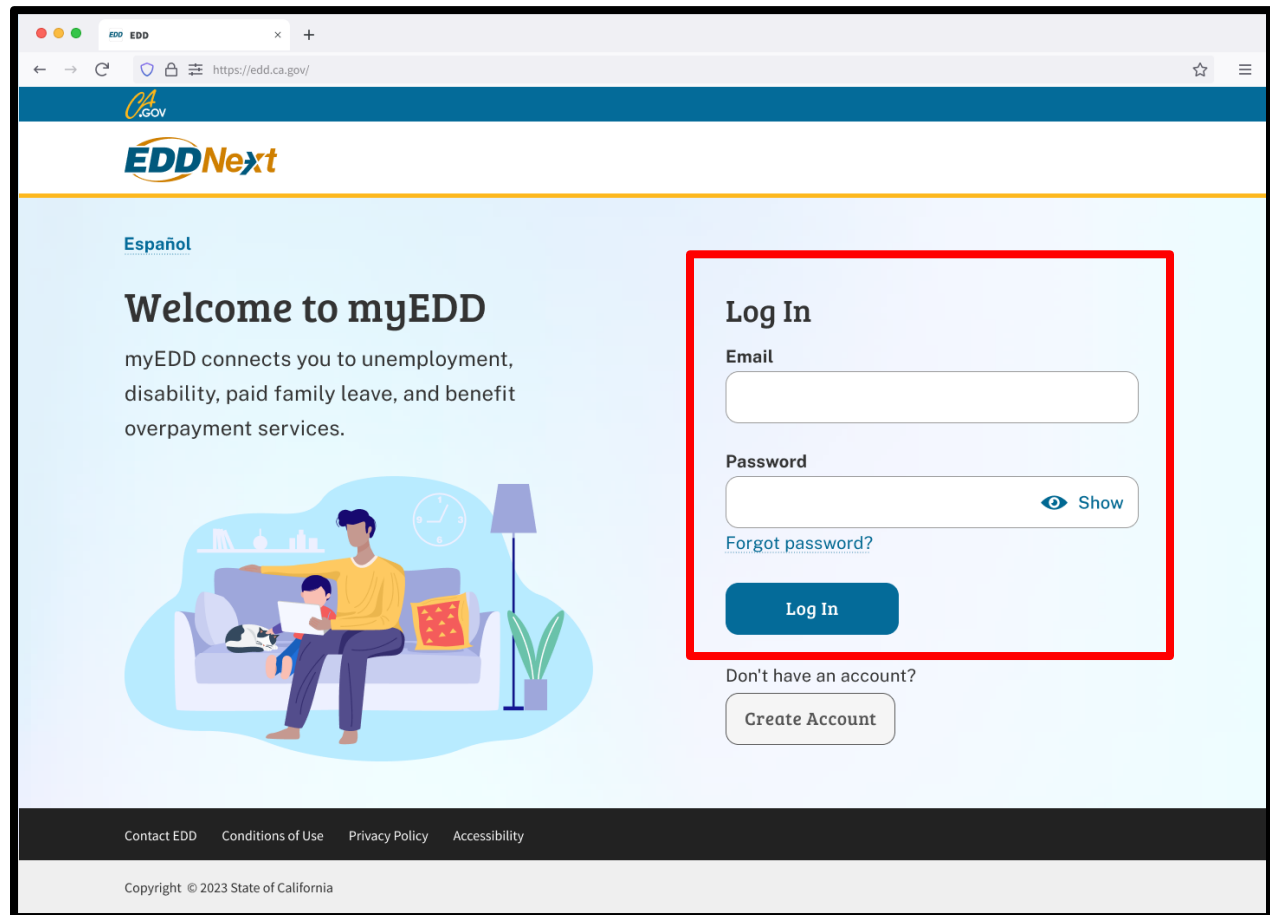
Step 1: Log in

Log in to myEDD to access SDI Online, update your email, password, security question, or verification option:

1. Visit [myEDD](https://myedd.ca.gov/).
2. Enter the email and password used to create your myEDD account.
3. Select **Log In**.

Note

For Spanish, select **Español**.



The screenshot shows the myEDD login page in a web browser. The page has a blue header with the 'CA.GOV' logo and 'EDDNext' branding. Below the header, there is a 'Español' link. The main content area features a 'Welcome to myEDD' message and an illustration of a person sitting on a couch. On the right side, there is a 'Log In' section highlighted with a red border. This section contains fields for 'Email' and 'Password', a 'Show' button for the password, a 'Forgot password?' link, and a 'Log In' button. Below the 'Log In' button is a 'Don't have an account?' link and a 'Create Account' button. The footer contains links for 'Contact EDD', 'Conditions of Use', 'Privacy Policy', and 'Accessibility', along with a copyright notice for 2023 State of California.

EDD

CA.GOV

EDDNext

Español

Welcome to myEDD

myEDD connects you to unemployment, disability, paid family leave, and benefit overpayment services.

Log In

Email

Password

Show

Forgot password?

Log In

Don't have an account?

Create Account

Contact EDD Conditions of Use Privacy Policy Accessibility

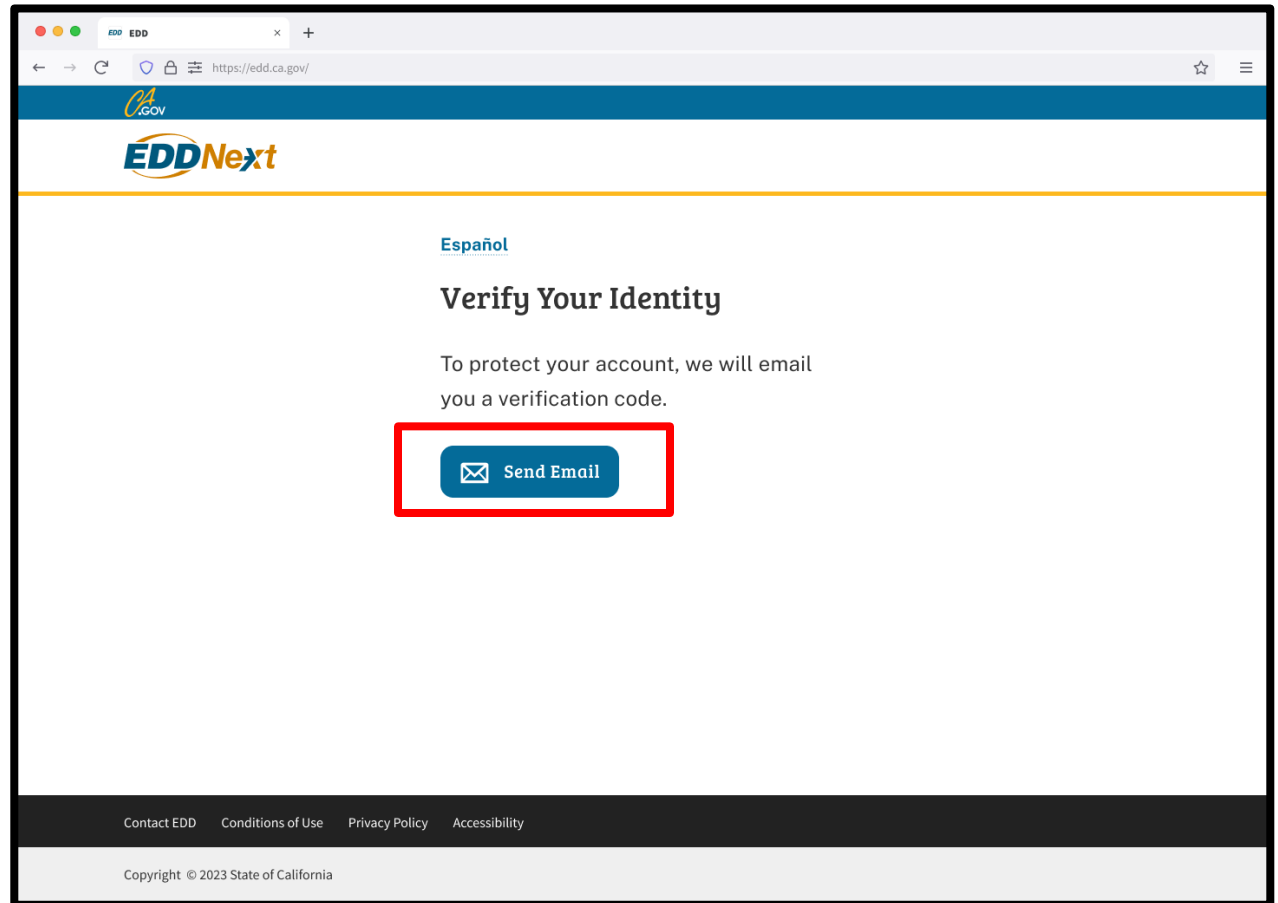
Copyright © 2023 State of California

Step 2: Verify Your Identity

To protect your account, we ask you to verify your identity every time you log in. In this example, the identity verification option is by email.

Select **Send Email**.

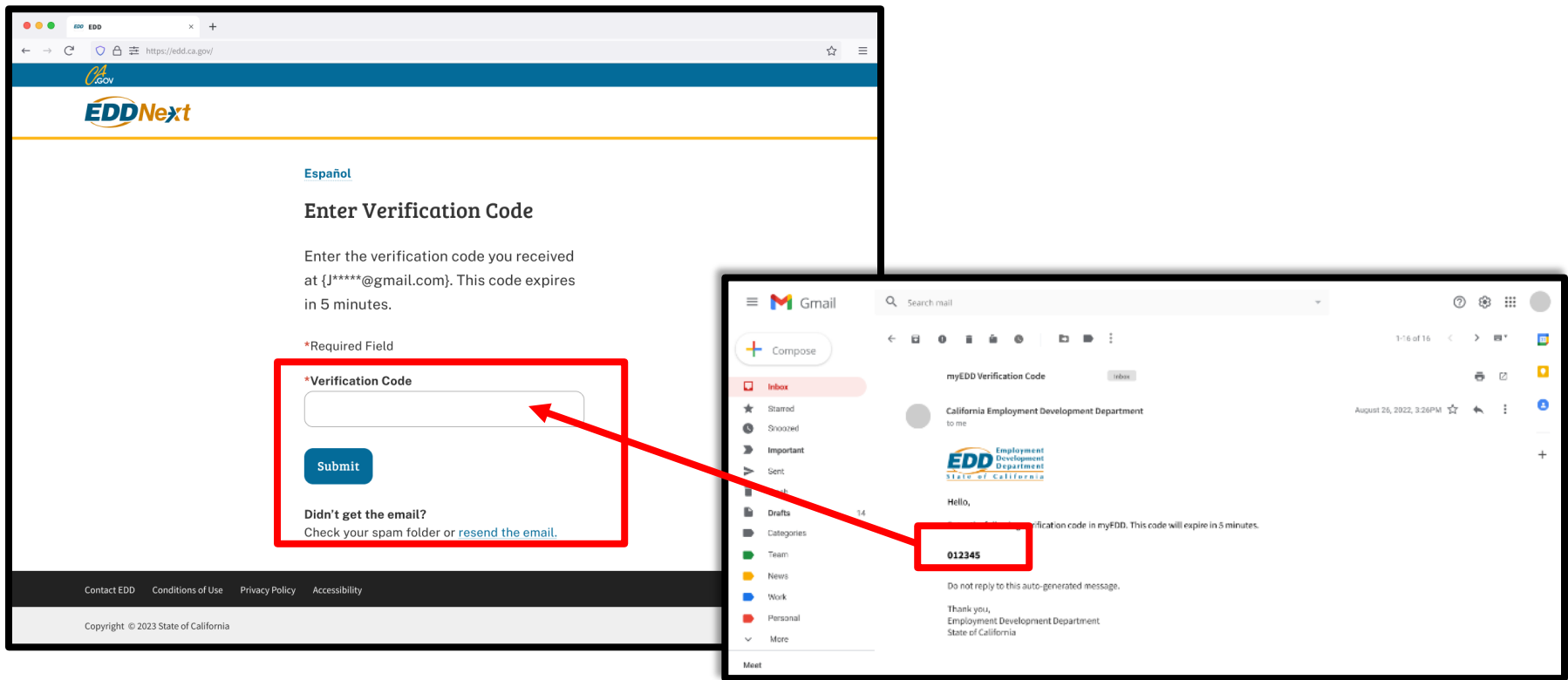
If you set up the login verification option as text message or phone call, follow the instructions based on that option.



Step 3: Enter Verification Code

Check your email for your verification code. This code expires in five minutes. Check your spam or junk folder if you do not get this email in your inbox.

- Enter your verification code and select **Submit**.
- Select **resend the email** if you do not get a code.

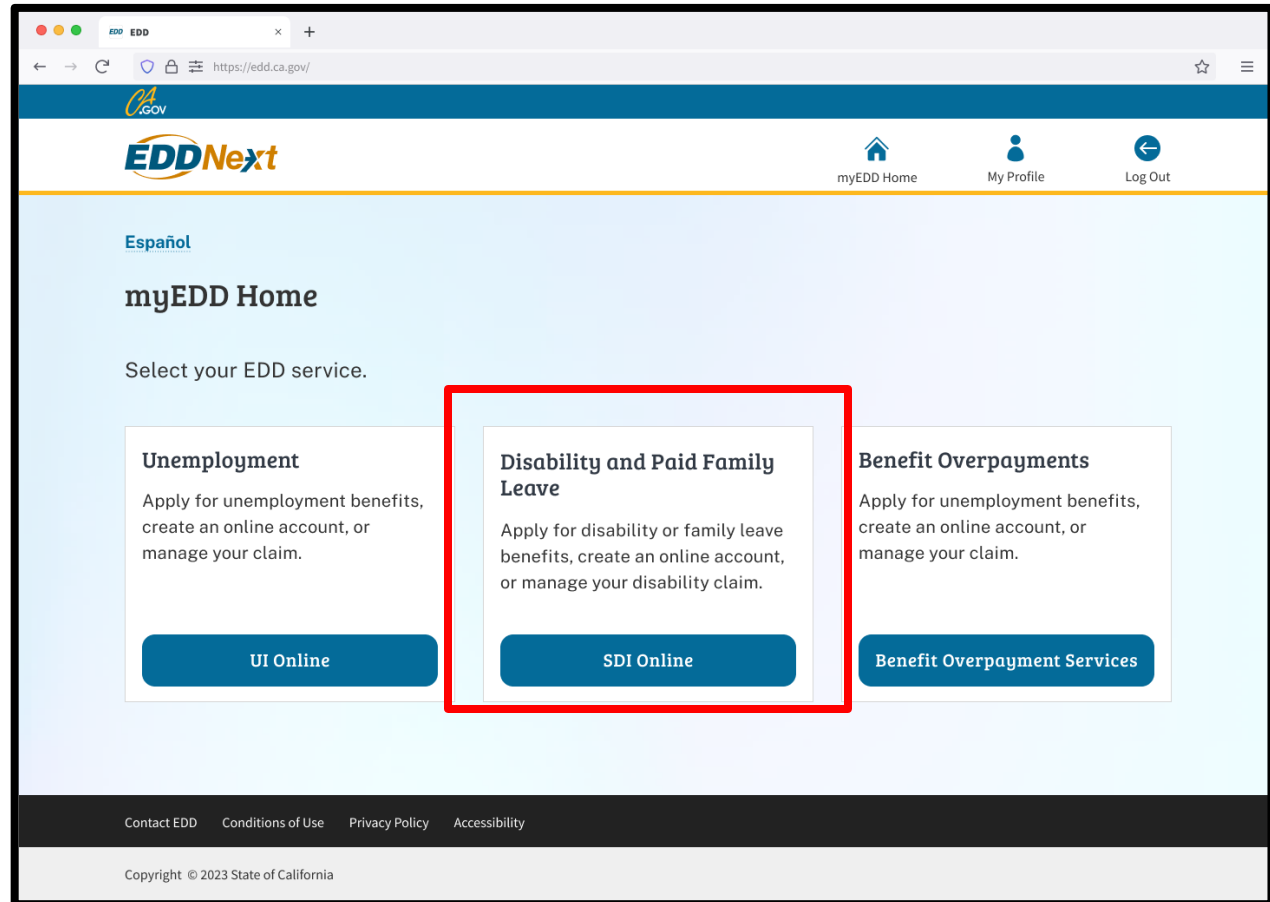


Step 4: Select SDI Online

From the myEDD homepage, select **SDI Online** to begin your SDI Online registration.

Note

Select **Log Out** in the top right corner of any screen to exit your account.



Step 5: Start Registration

You are sent to the SDI Online Registration Account Type screen.

Read the instructions.

Select **Register as a Physician/Practitioner** link.

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 or Paid Family Leave claims for your patients.

For California providers, you will need medical license information (as filed with the California Department of Consumer Affairs).

For out-of-state providers, call 1-855-342-3645 before you complete your registration.

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.

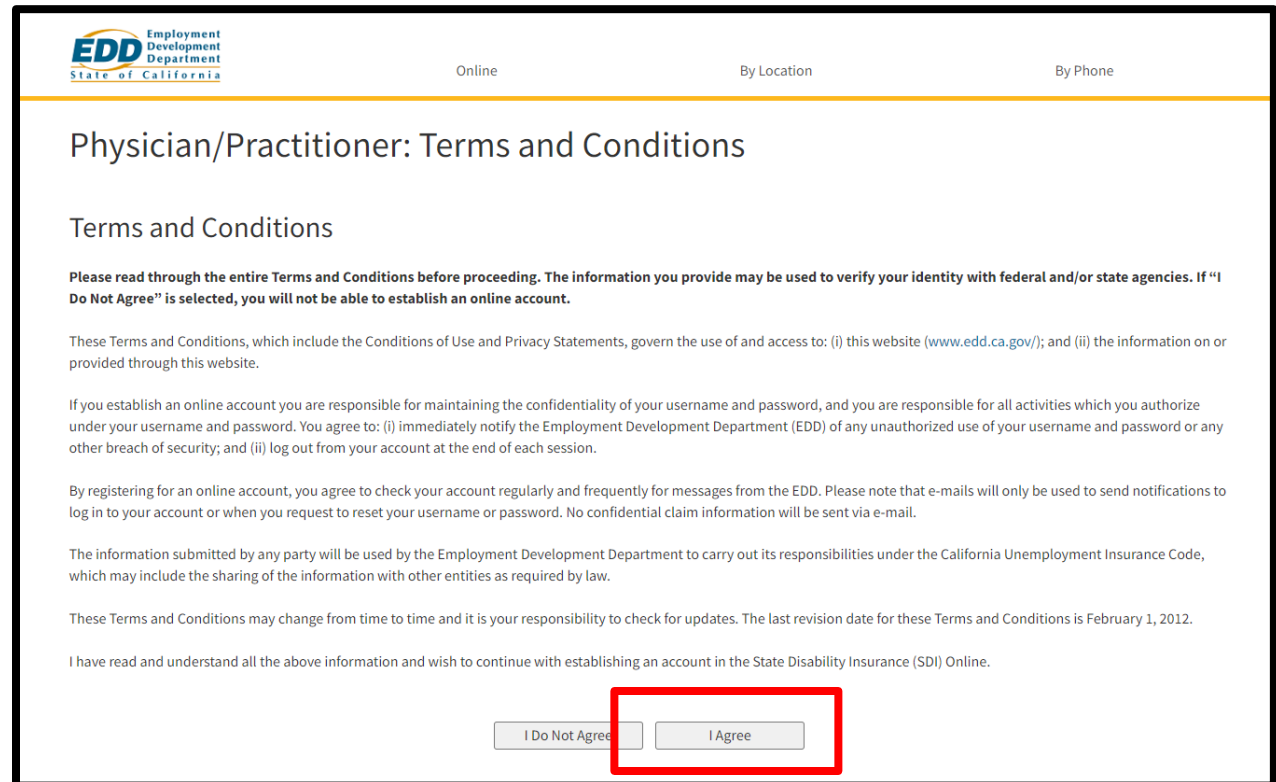
Note: You must match the information entered by the physician/practitioner.

[Register as a Representative](#)

Step 6: Terms and Conditions

Next, review the terms and conditions. Select **I Agree**.

You must agree to these terms and conditions to create an online account.



EDD Employment Development Department State of California

Online By Location By Phone

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.

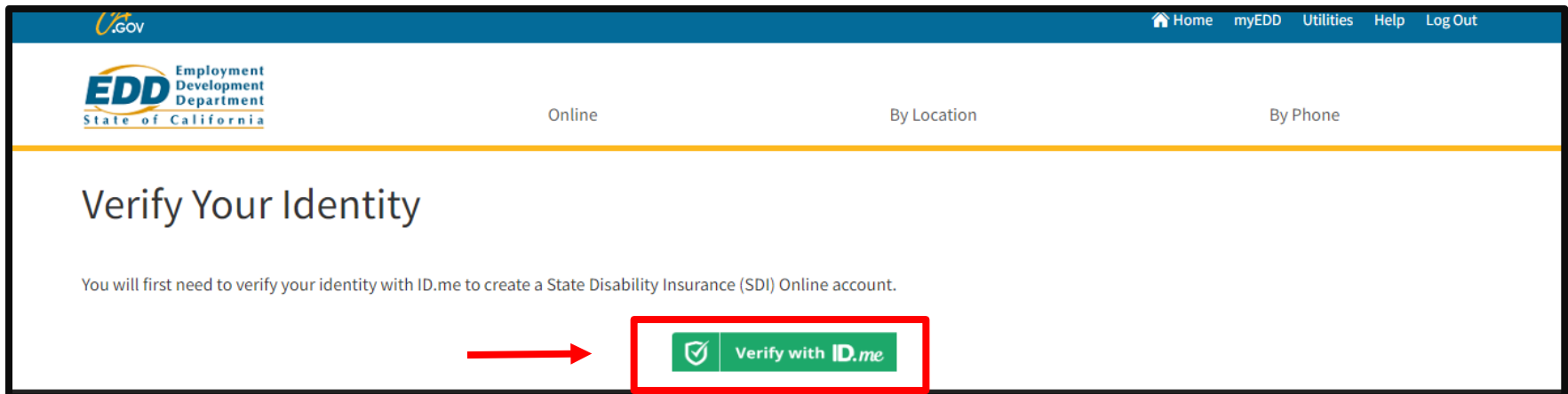
The information submitted by any party will be used by the Employment Development Department to carry out its responsibilities under the California Unemployment Insurance Code, which may include the sharing of the information with other entities as required by law.

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.

Step 7: ID.me

We are partnered with ID.me to verify the identity of the physician/practitioner. You must verify your identity with ID.me to create an SDI Online account. Select **Verify with ID.me** to start the ID.me registration and verification process. For help with ID.me, visit [California Disability Insurance and ID.me](#).



Step 8: Allow Sharing

Once you complete the ID.me verification process, ID.me will have the option to **Allow** or **Deny** sharing your ID.me identity information with us.

If you deny sharing your ID.me information with us, you will be redirected to SDI Online and the following message will display, “You must share your identity with the EDD to create an account.”

If you select deny by mistake, select **Verify with ID.me** to try again.

If you allow sharing your ID.me information with us, you will be redirected to SDI Online to complete the SDI Online registration.

The screenshot displays the "Verify Your Identity" page on the EDD State of California website. At the top, there is a blue header with the "CA GOV" logo and navigation links for "Home", "Help", and "Log Out". Below the header, the EDD logo and "State of California" text are visible. The main content area has a yellow banner with the text "Action Required" and a message: "You must share your identity with the EDD to create an account. Select **Verify with ID.me** to share your identity." Below this message, there is a text line: "You will first need to verify your identity with ID.me to create a State Disability Insurance (SDI) Online account." At the bottom of the main content area, there are two buttons: "Cancel" and "Verify with ID.me". A red arrow points to the "Verify with ID.me" button, which is highlighted with a red box. The footer contains links for "Back to Top", "Contact EDD", "Conditions of Use", "Privacy Policy", and "Accessibility". The footer also includes the text "Copyright © 2022 State of California" and "Build Environment: 'Development', Build Number: 1.0.0".

Step 9: Enter Your Information

The system automatically fills certain information from ID.me and are read-only fields:

- Your full legal name.
- Date of birth.
- Last four digits of your Social Security number.
- National Provider Identifier or NPI number.

You must enter the following personal and professional information:

- License type, number, and expiration date.
- Medical school name and graduation year.
- Address and phone number as provided to the Department of Consumer Affairs.

You must complete the fields marked with a red asterisk (*).

Select **Next** to proceed.

The screenshot shows the 'Physician/Practitioner: Account Verification Information' form. The form is divided into three main sections: Personal Information, Physician/Practitioner Information, and Address and Phone Number. The Personal Information section includes fields for First Name, Middle Name, Last Name, a checkbox for 'Have you used any other last names?', a Suffix field, E-mail Address, Date of Birth, and Last four digits of Social Security Number. The Physician/Practitioner Information section includes NPI Number, License Type (a dropdown menu), Physician/Practitioner License Number, License Expiration Date, Medical School Name, and Medical School Year Graduated. The Address and Phone Number section includes a radio button for 'US' or 'International', Address Line 1, Address Line 2, City, State (a dropdown menu), ZIP Code, Phone Number (with a separate field for Extension), and a checkbox for 'Check here if the phone number is international'. At the bottom of the form, there are 'Cancel' and 'Next' buttons. The 'Next' button is highlighted with a red rectangle.

Physician/Practitioner: Account Verification Information

*Indicates Required Field

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

Personal Information

First Name: Jonathan Jonatha
Middle Name:
Last Name: Ramakanthreddypamireddy
*Have you used any other last names? ☐ Yes ☒ No
Suffix: (If you have no suffix, leave blank.)
E-mail Address: SDIO_integration_2547@SDIOT2.com
Date of Birth: 10-15-1985
Last four digits of Social Security Number: XXX-XX-5555

Physician/Practitioner Information

NPI Number: 5000011655
*License Type: Physician Assistant (PA)
*Physician/Practitioner License Number: PAS4554544
*License Expiration Date: 06152025
*Medical School Name: School
*Medical School Year Graduated: 1985

Address and Phone Number

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

☒ US ☐ International

*Address Line 1: 10833 Folsom blvd
Address Line 2:
*City: Rancho Cordova
*State: CA
*ZIP Code: 95670
*Phone Number: 6306306302 Ext: 100
☐ Check here if the phone number is international

Cancel Next

Step 10: Communication Preference

On the Personal Profile Information screen, select how you want to get notifications.

If you select to get notifications by email, you must log in to your account to access your messages.

Some documents are required to be sent by mail.

CA.GOV Home myEDD Utilities Help Log Out

EDD Employment Development Department State of California Online By Location By Phone

Physician/Practitioner: Personal Profile Information

*Indicates Required Field

Communication Preferences

*How do you want to receive notifications?

☒ Email

☐ Paper mail

☐ I do not want to receive notifications. I will be checking SDI Online regularly.

Note: We are required to send some documents by paper mail.

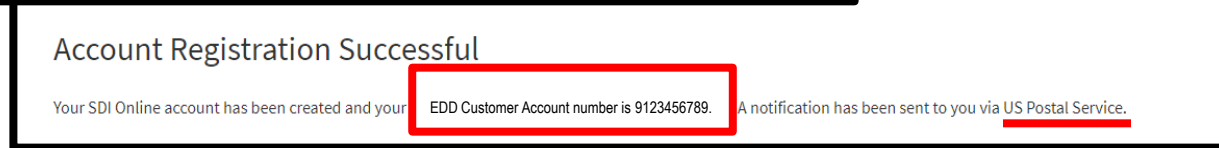
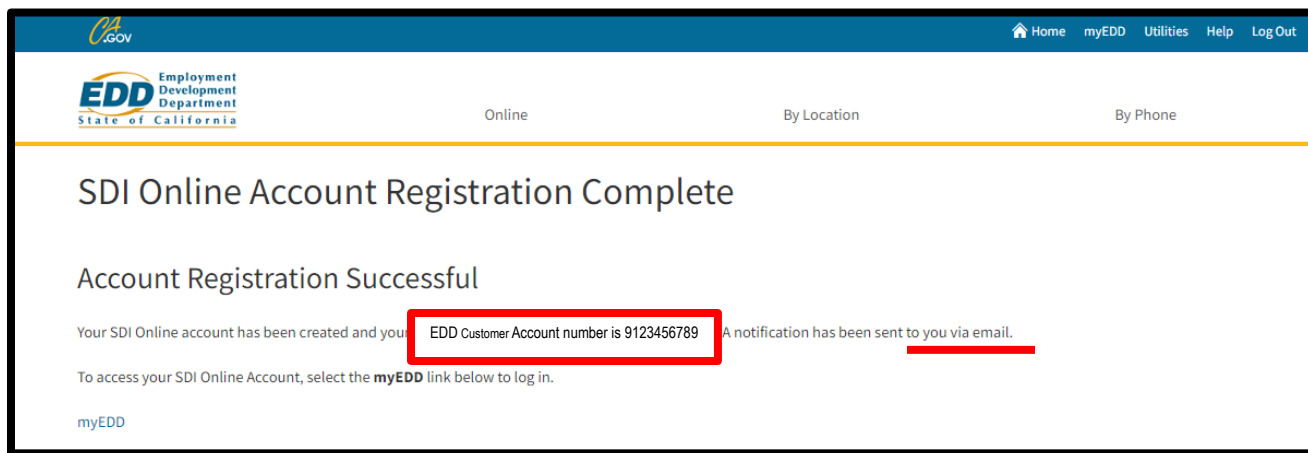
Cancel Submit

Step 11: Registration Complete

Be sure to save your EDD Customer Account Number (EDDCAN).

- If you selected electronic communication, a notification confirming your new account is sent to your email.
- If you selected paper communication, a letter confirming your new account is mailed to your address.

You may now log in to myEDD to access your new SDI Online account.





Access Your SDI Online Account

Learn more about how to access your online account and update personal information.



Get Started

EDD EDD

https://edd.ca.gov/

CA.gov

EDDNext

Español

Welcome to myEDD

myEDD connects you to unemployment, disability, paid family leave, and benefit overpayment services.

Log In

Email

Password

Show

[Forgot password?](#)

Log In

Don't have an account?

Create Account

Contact EDD Conditions of Use Privacy Policy Accessibility

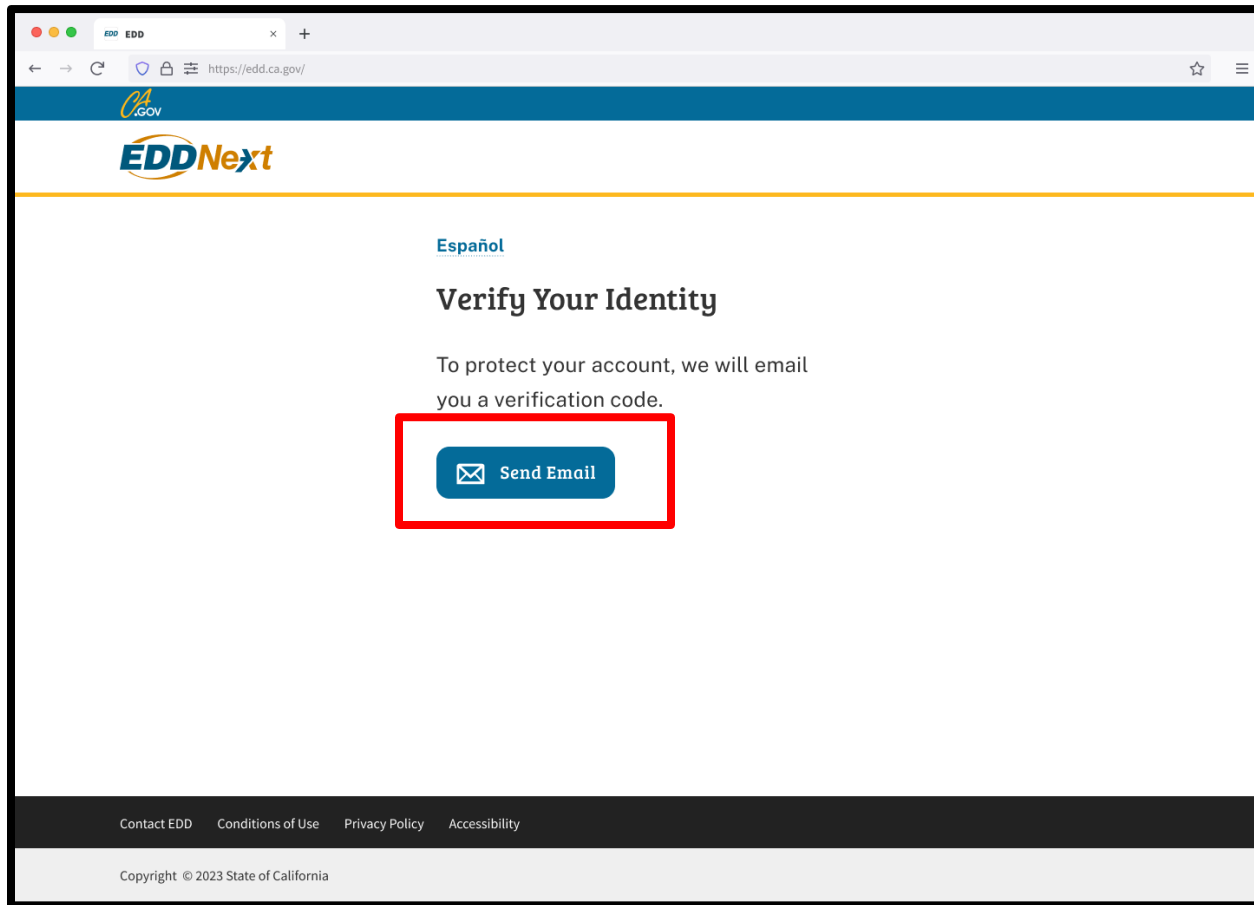
Copyright © 2023 State of California

Note

For Spanish, select **Español**.

Log in to myEDD to access your SDI Online account and update your email, password, security question, or verification option:

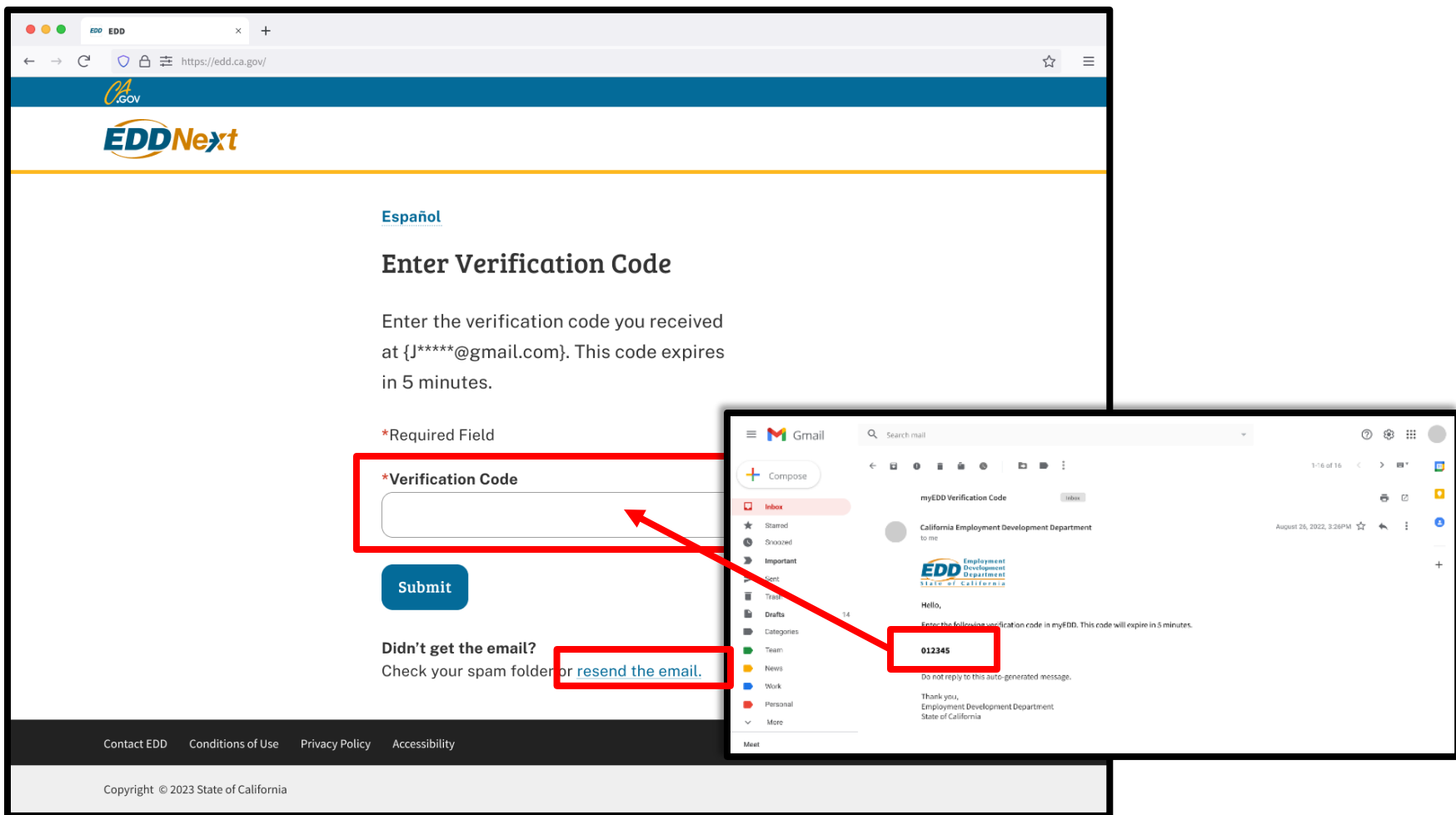
1. Visit [myEDD](#).
2. Enter the email and password used to create your myEDD account.
3. Select **Log In**.



To protect your account, we ask you to verify your identity every time you log in. In this example, the identity verification option is by email.

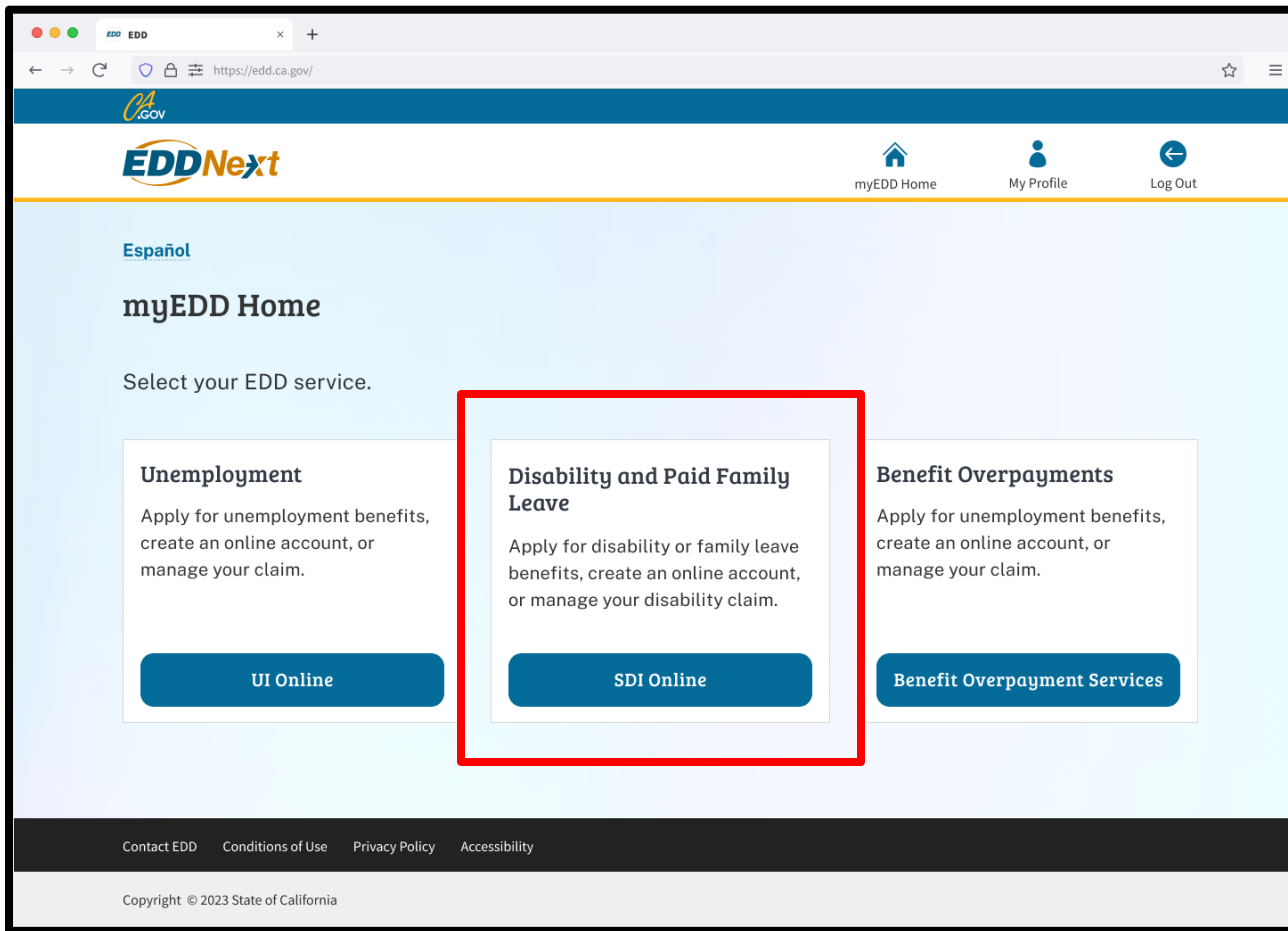
Select **Send Email**.

If you set up the login verification option as text message or phone call, follow the instructions based on that option.



Check your email for your verification code. This code expires in five minutes. Check your spam or junk folder if you do not get this email.

- Enter your verification code and select **Submit**.
- Select **resend the email** if you do not get a code.



Note

Select **Log Out** in the top right corner of any screen to exit your account.

From the myEDD homepage, select **SDI Online** to begin your SDI Online certification.

On your SDI Online homepage, under the Search section, there are four ways to search for forms.

Search by the patient's last name and one of the following:

- The **Last four digits of SSN** or **Patient Receipt Number** and patient's date of birth.
- The **Claim ID** to submit additional medical.
- The **My Receipt Number** to review forms you have submitted.
- The **Patient/PFL Receipt Number** to submit Paid Family Leave forms.

The screenshot shows the EDD (Employment Development Department) SDI Online homepage. The top navigation bar includes links for SDI Home, Inbox, Draft, and Profile. The main content area is titled "Home" and includes a "License Information" table with columns for Licensee Name and License Number. Below this is a "Message Center" section with links for Inbox and Saved Drafts. The "Search" section is highlighted with a red box and contains a search form with the following fields:

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 2525X, 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: Claim ID [dropdown] [text input]
*Patient/PFL Last Name: [text input]
Date of Birth: [text input (MMDDYYYY)]
[Cancel] [Search]

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:

The main menu appears on most screens and has additional options.

- **Inbox:** Access the Message Center for messages from the EDD.
- **Draft:** Locate drafts of forms previously started, but not completed. Saved Drafts are deleted after 30 days.
- **Profile:** Update your phone number and communication preferences.

You can only update your phone number and communication preference in your SDI Online profile.

Address updates must be sent to the Medical Board with the Department of Consumer Affairs (DCA). We get this information after the DCA updates your address and we complete a license validation. Contact the DCA if you have trouble updating your address.

Go to your myEDD homepage to update your:

- Email address
- Password
- Security question
- Verification options

For instructions on adding treatment addresses, continue to the next section.

The screenshot shows the 'Physician/Practitioner Update Personal Profile Information' page on the EDD website. The page has a blue header with the EDD logo and navigation links: Home, Help, Log Out, SDI Home, Inbox, Draft, Profile, and a 'Change:' button highlighted with a red box. The main content area is titled 'Physician/Practitioner Update Personal Profile Information' and includes a note: '*Indicates Required Field'. Below this, it says 'Select the Benefit Programs Online link above to update:' followed by a list: Email Address, Password, Security Questions, and Personal Image/Caption. The section 'Physician/ Practitioner Information' contains a note: '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.' The form fields are: Licensee Name: John Feelgood; License Type: Physician or Surgeon (MD); Physician/Practitioner License Number: CA00000; License Expiration Date: 08-31-2019; Address: 101010 7th Street, Los Angeles, CA 90101; Phone Number: 8963025741 (with an 'Ext:' field); Medical School Name: Test ABC; Medical School Year Graduated: 2008; E-mail Address: sample@test.com; NPI Number: 1780999999. There is a checkbox for 'Check here if the phone number is international'. The 'Communication Preferences' section has a note: '*How do you want to receive notifications?' with three radio buttons: Email, Paper mail (selected), and I do not want to receive notifications. I will be checking SDI Online regularly. A 'Note' at the bottom states: 'Note: We are required to send some documents by paper mail.' A 'Cancel' button is at the bottom right. The footer contains links: Back to Top, Contact EDD, Conditions of Use, Privacy Policy, and Accessibility.

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: 08-31-2019

Address: 101010 7th Street
Los Angeles, CA
90101

Phone Number: 8963025741 Ext:

☐ Check here if the phone number is international

Medical School Name: Test ABC

Medical School Year Graduated: 2008

E-mail Address: sample@test.com

NPI Number: 1780999999

Communication Preferences

*How do you want to receive notifications?

☐ Email

☒ Paper mail

☐ I do not want to receive notifications. I will be checking SDI Online regularly.

Note: We are required to send some documents by paper mail.

Cancel

Back to Top Contact EDD Conditions of Use Privacy Policy Accessibility



Add a Treatment Address

Learn more about how to add treatment addresses to your account.



[Get Started](#)

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 SDI Online homepage.

The screenshot shows the EDD (Employment Development Department) website for the State of California. The page title is "Physician/Practitioner Update Personal Profile Information". A red box highlights the "Change:" dropdown menu in the top right corner, with a red arrow pointing to the "Manage Treatment Address" option. The page also displays the user's profile information, including Licensee Name, License Type, License Number, Expiration Date, Address, and Phone Number.

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: 9161234567 Ext:

☐ Check here if the phone number is international

Medical School Name:

Medical School Year Graduated:

From the menu:

- Hover your cursor over **Change** (this option is only available after selecting **Profile**).
- Select **Manage Treatment Address** from the Physician/Practitioner Update Personal Profile Information screen.
- You will be sent to the Treatment Address screen.

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

Select the **Add** button to be sent to the Add Modify Treatment Address screen.

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

Cancel **Save**

Complete the open fields on the Add Modify Treatment Address screen.

You must complete the fields marked with a red asterisk (*).

Select **Save**.

Note

If you practice at multiple locations, repeat this process to add more treatment addresses.

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

All treatment addresses you enter are displayed on the Treatment Address screen.

- Select **Modify** or **Delete** to manage each treatment address.
- To add additional treatment addresses, select **Add**.

Note

Treatment addresses will appear as selection options when you or your authorized representatives complete online medical forms.



Assign a Medical Representative

Learn more about how to add your
medical representatives to your account.



[Get Started](#)

Physicians /practitioners may assign an unlimited number of representatives to complete and submit medical forms on their behalf.

It is the physician/practitioner's responsibility to remove representatives that no longer work in their medical offices.

The screenshot shows the EDD State of California SDI Home page. The top navigation bar includes links for 'SDI Home', 'Inbox', 'Draft', and 'Profile'. The 'Profile' link is highlighted with a red rectangle. Below the navigation bar, the page displays 'Home' with a note '*Indicates Required Field'. The 'License Information' section shows a table with columns 'Licensee Name' and 'License Number', containing the entry 'John Feelgood' with license number 'CA00000'. Below this is a 'Message Center' section with links for 'Inbox [New: 0, Total: 0]' and 'Saved Drafts [Total: 0]'. The 'Search' section provides instructions for submitting various forms and certificates.

Licensee Name	License Number
John Feelgood	CA00000

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.

Before the medical representative can register for an SDI Online account, the physician/practitioner must add the medical representative's personal information and treatment address in their SDI Online profile.

To add a physician/practitioner representative:

- Select **Profile** from the main menu.

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: 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:

Manage Treatment Address

Manage Medical
Representative

From the Physician/Practitioner Update Personal Profile Information screen:

- Hover over **Change** on the main menu (this option is only available after selecting **Profile**).
- 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 screen:

- 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:

On the Add Modify Medical Representative screen:

- Complete all open fields. You must complete the fields marked with a red asterisk (*).
- Select a treatment address.
- Select **Save** to add your representative.

Note

If the treatment address for your medical representative is not listed, you must select **Cancel** and add the treatment address to your profile.

Your medical representative must enter the same personal information you enter here when registering for their representative SDI Online account or they will get an error.

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

Added medical representatives are displayed on the Add Delete Medical Representative screen.

- Select **Modify** to update information for a specific medical representative.
- Select **Delete** to delete a specific medical representative.
- Select **Add** to add additional representatives.



Register as a Medical Representative in SDI Online

Learn more about how representatives of physicians/practitioners register in SDI Online.



[Get Started](#)

The screenshot shows the myEDD login page. At the top, there's a blue header with the EDDNext logo and a language selector set to "Español". Below the header, the text "Welcome to myEDD" is displayed, followed by a description of the service. To the left of the login form is an illustration of a person sitting on a couch with a laptop. The login form itself is highlighted with a red border and contains fields for "Email" and "Password", a "Show" button for the password, a "Forgot password?" link, and a "Log In" button. Below the form is a link to "Create Account" for users who don't have an account. The footer contains links for "Contact EDD", "Conditions of Use", "Privacy Policy", and "Accessibility", along with a copyright notice for 2023 State of California.

To register for a new SDI Online account type (Claimant, employer, physician, representative, etc.) you must first complete a one-time registration in myEDD.

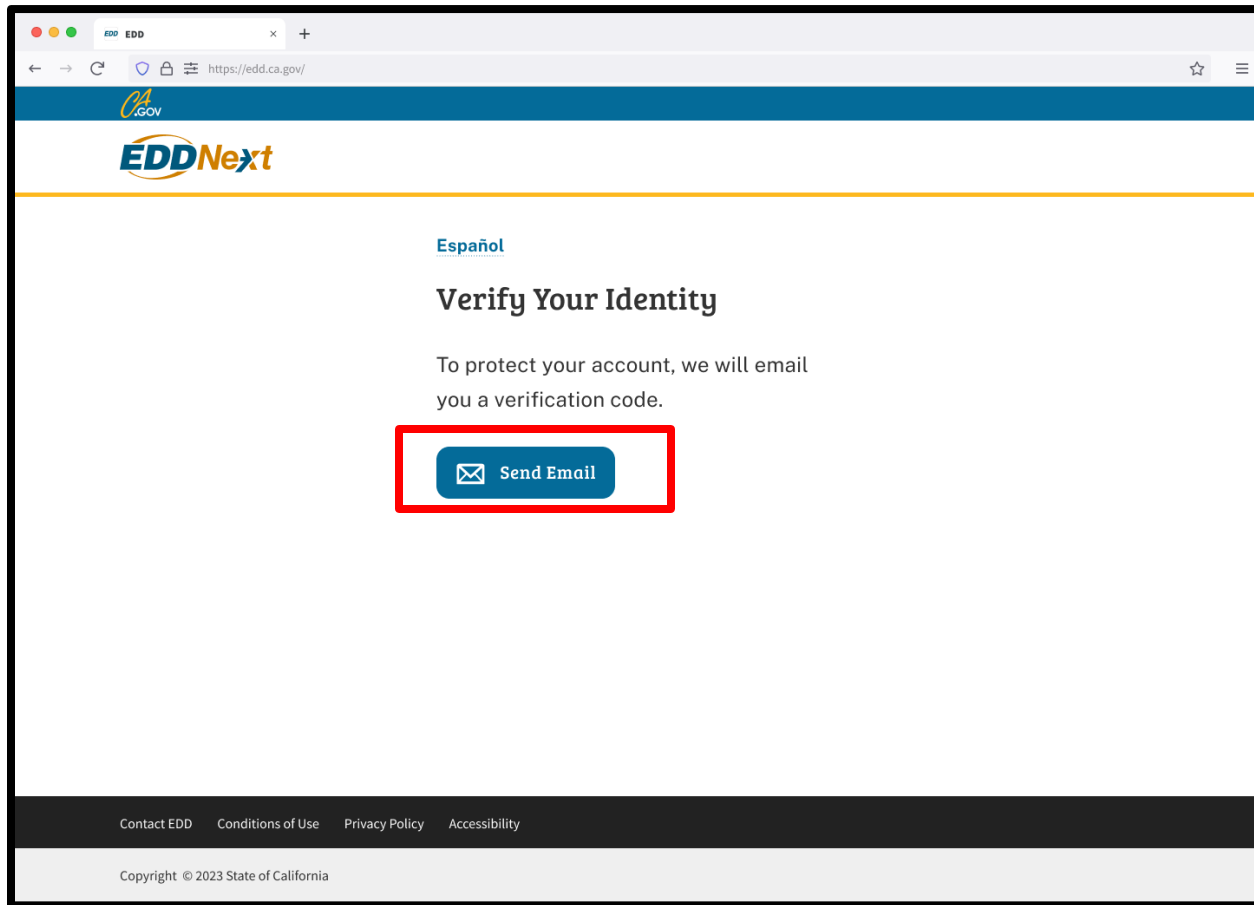
Use the [Create Your myEDD Account](#) section of this tutorial for instructions.

Note

For Spanish, select **Español**.

Log in to myEDD to register as a physician/practitioner representative in SDI Online:

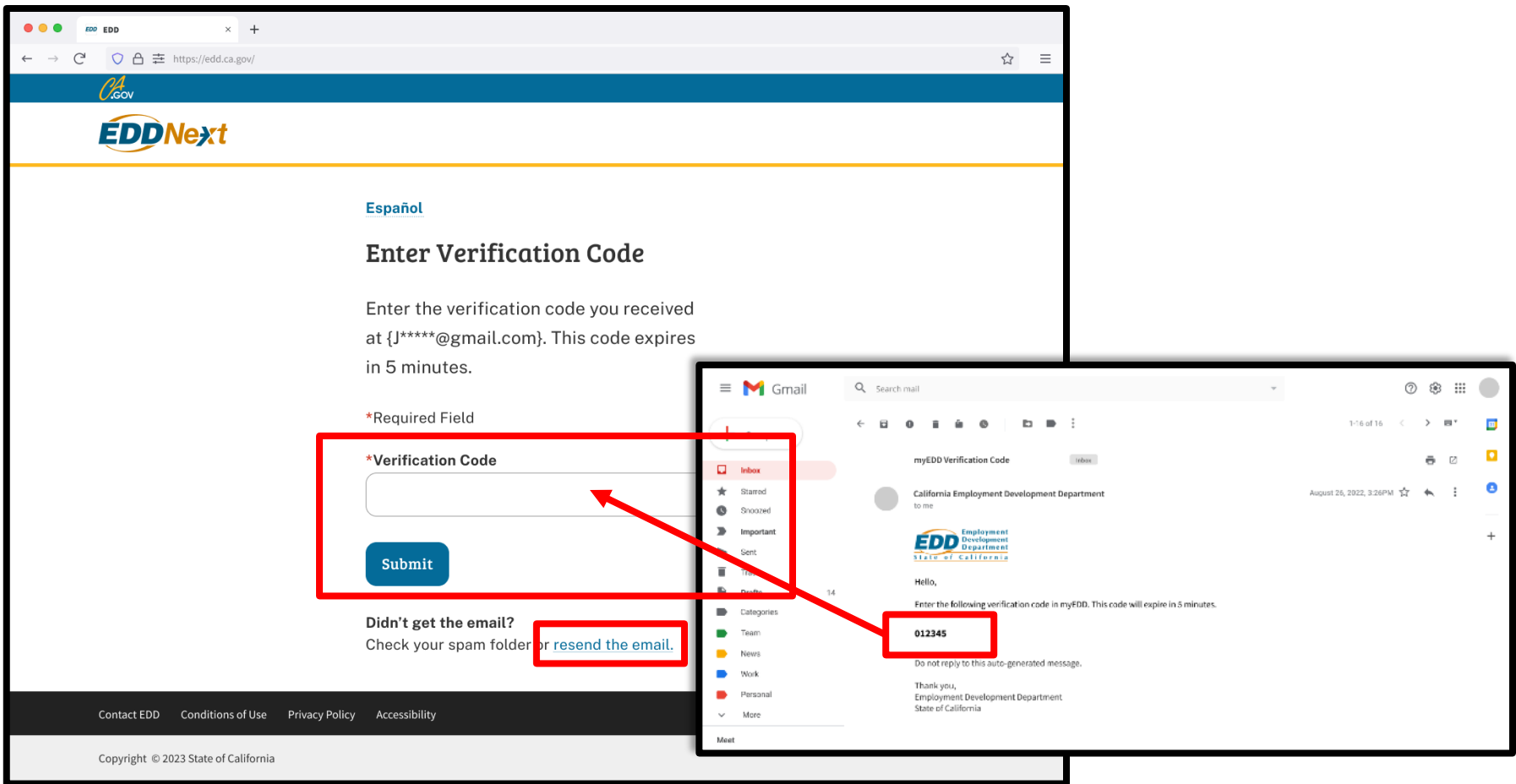
1. Visit [myEDD](#).
2. Enter the email and password used to create your myEDD account.
3. Select **Log In**.



To protect your account, we ask you to verify your identity every time you log in. In this example, the identity verification option is by email.

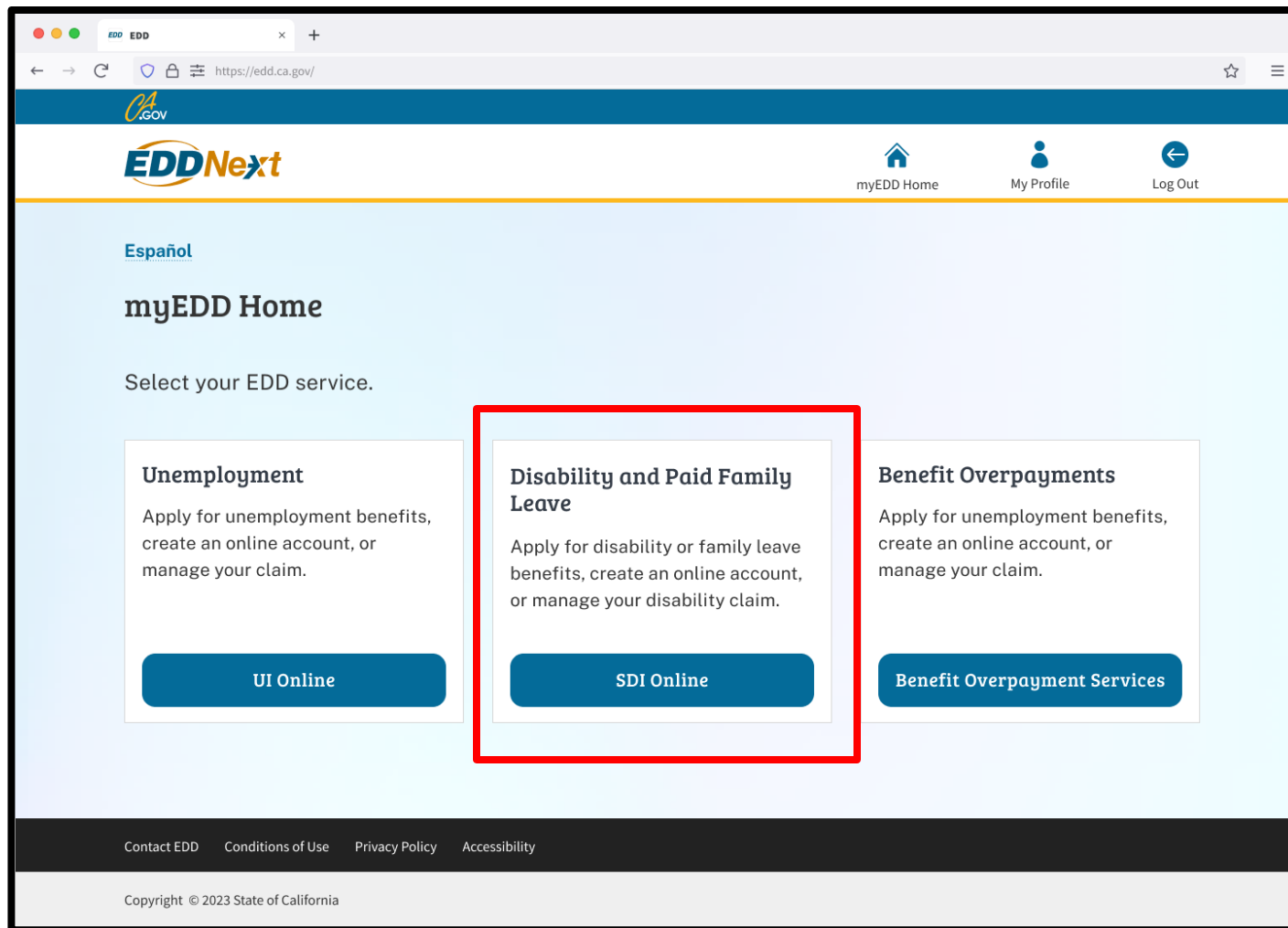
Select **Send Email**.

If you set up the login verification option as text message or phone call, follow the instructions based on that option.



Check your email for your verification code. This code expires in five minutes. Check your spam or junk folder if you do not get this email in your inbox.

- Enter your verification code and select **Submit**.
- Select **resend the email** if you do not get a code.



Note

Select **Log Out** in the top right corner of any screen to exit your account.

From the myEDD homepage, select **SDI Online** to begin your SDI Online registration.

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 sent to the SDI Online Registration Account Type screen.

Select the **Register as a Representative** link.

Note

You will not be able to register as a representative until the licensed health professional authorizing your account has added your information to their SDI Online profile.

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.

Next, review our terms and conditions.

Select **I Agree**.

You must agree to these terms and conditions to create an account.

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:	<input type="text"/>
Middle Name:	<input type="text" value="(If you have no middle name, leave blank.)"/>
*Last Name:	<input type="text"/>
Suffix:	<input type="text" value="(If you have no suffix, leave blank.)"/>
E-mail Address:	JohnSmith@gmail.com
*Date of Birth:	<input type="text" value="(MMDDYYYY)"/>
*Last four digits of Social Security Number:	<input type="text"/>

Cancel

Next

Enter the following personal information. You must complete the fields marked with a red asterisk (*).

- Your full legal name.
- Date of birth.
- Last four digits of your Social Security number.

If you get an error after entering your information, contact the physician/practitioner authorizing your account to make sure your entries match.

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

Note

If you select to get notifications by email, we send you emails to notify you that messages are available in your account. However, it may be necessary to send some documents by mail.

On the Personal Profile Information screen:

- Verify the treatment address.

If an incorrect treatment address is listed, the physician/practitioner authorizing your account must update the address from their SDI Online account profile.

- Enter a phone number so we can contact you during business hours, if needed.
- Select your communication preference.
- Select **Submit**.

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.

Your registration is now complete.

- If you selected electronic communication, a notification confirming your new account is sent to your email.
- If you selected paper communication, a letter confirming your new account is mailed to your address.

You may now log in to myEDD to access your new SDI Online account.

The screenshot shows the myEDD website interface in Spanish. At the top, there's a blue header with the 'CA.gov' logo and 'EDDNext' branding. Below the header, the word 'Español' is displayed. The main content area is light blue and features a 'Welcome to myEDD' section on the left with a description of the service and an illustration of a person on a couch. On the right, a 'Log In' section is highlighted with a red border. This section contains input fields for 'Email' and 'Password', a 'Show' button for the password, a 'Forgot password?' link, a 'Log In' button, and a 'Create Account' button. The footer includes links for 'Contact EDD', 'Conditions of Use', 'Privacy Policy', and 'Accessibility', along with a copyright notice for 2023 State of California.

EDD EDD

https://edd.ca.gov/

CA.gov

EDDNext

Español

Welcome to myEDD

myEDD connects you to unemployment, disability, paid family leave, and benefit overpayment services.

Log In

Email

Password

 [Show](#)

[Forgot password?](#)

[Log In](#)

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

[Create Account](#)

[Contact EDD](#) [Conditions of Use](#) [Privacy Policy](#) [Accessibility](#)

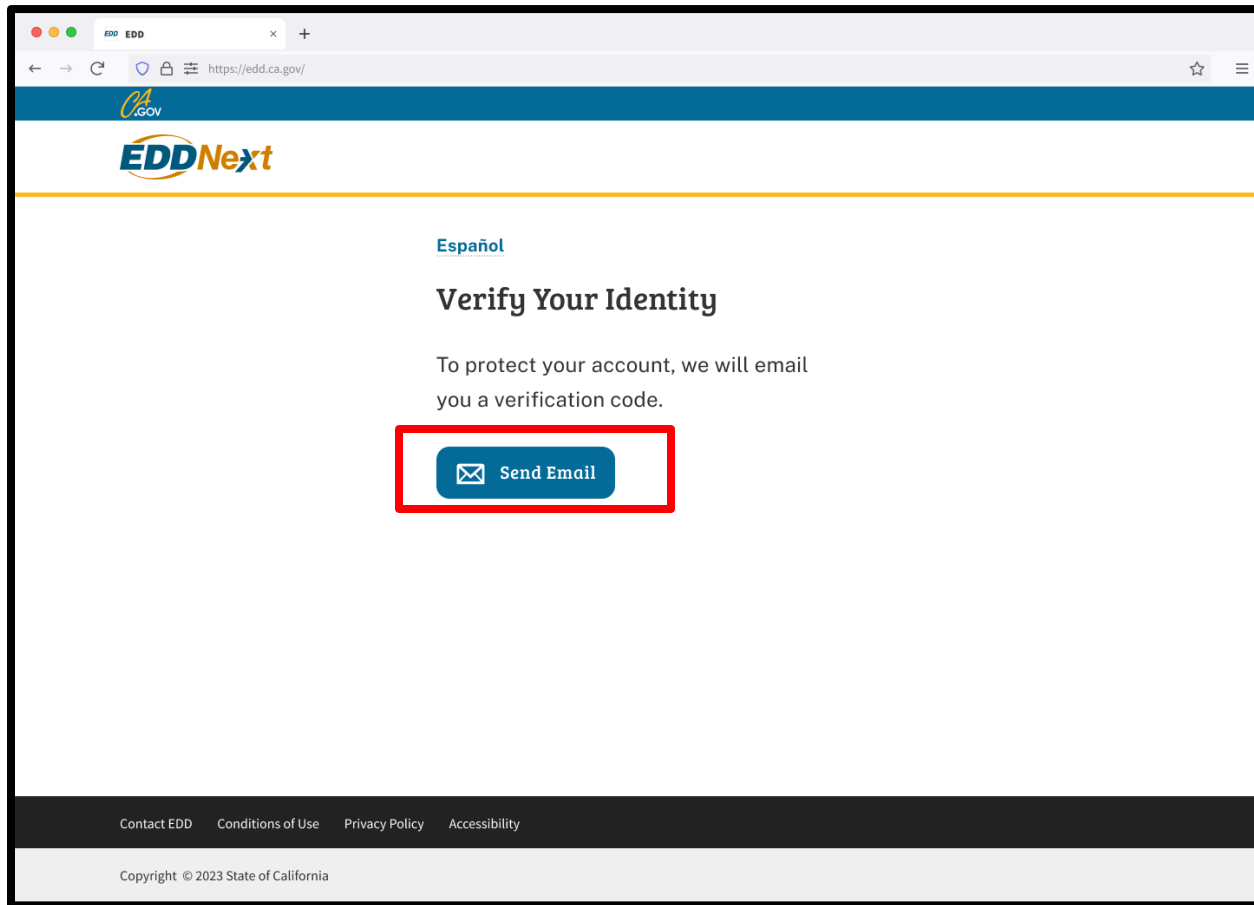
Copyright © 2023 State of California

Note

For Spanish, select **Español**.

Log in to myEDD to access SDI Online:

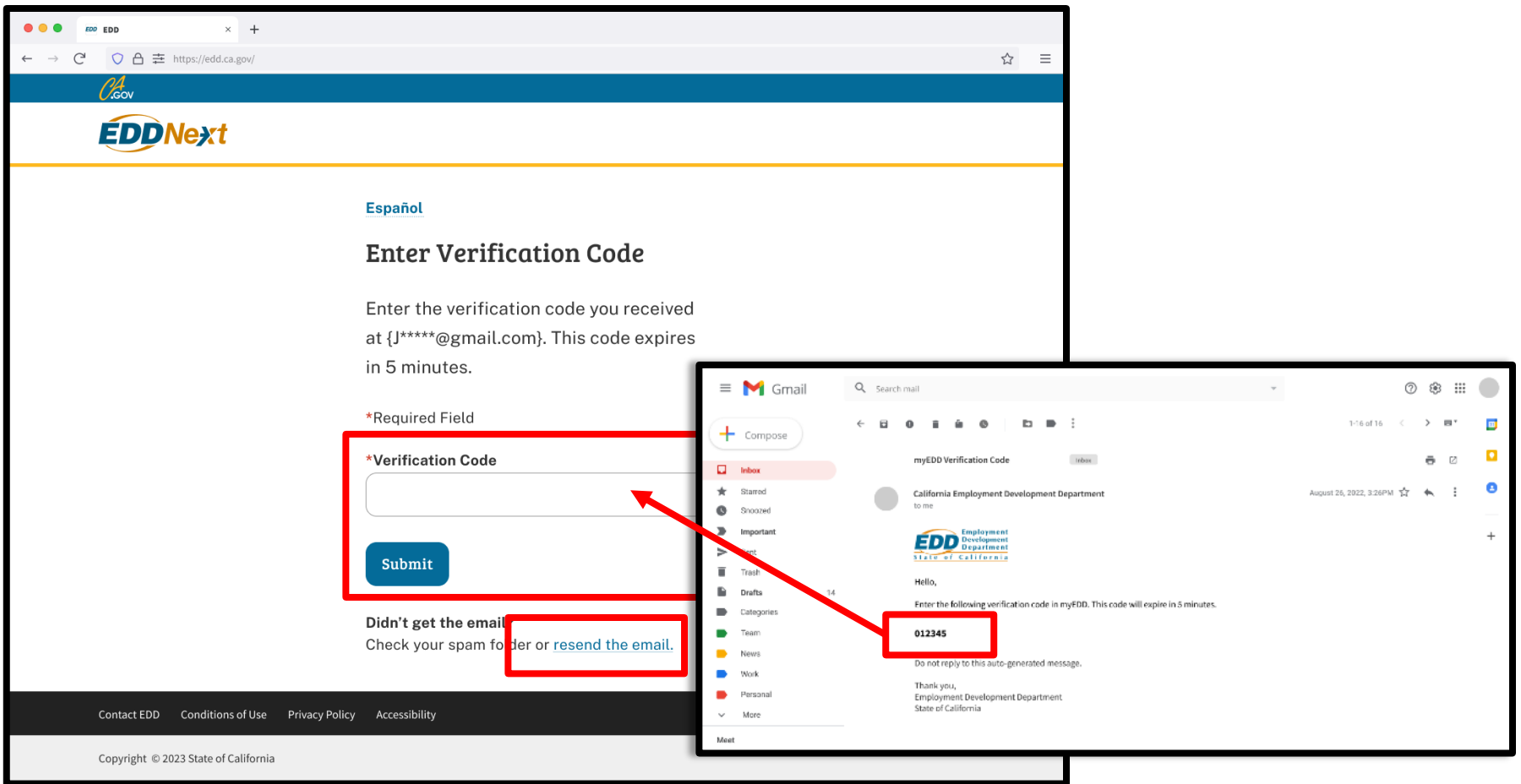
1. Visit [myEDD](#).
2. Enter the email and password used to create your myEDD account.
3. Select **Log In**.



To protect your account, we ask you to verify your identity every time you log in. In this example, the identity verification option is by email.

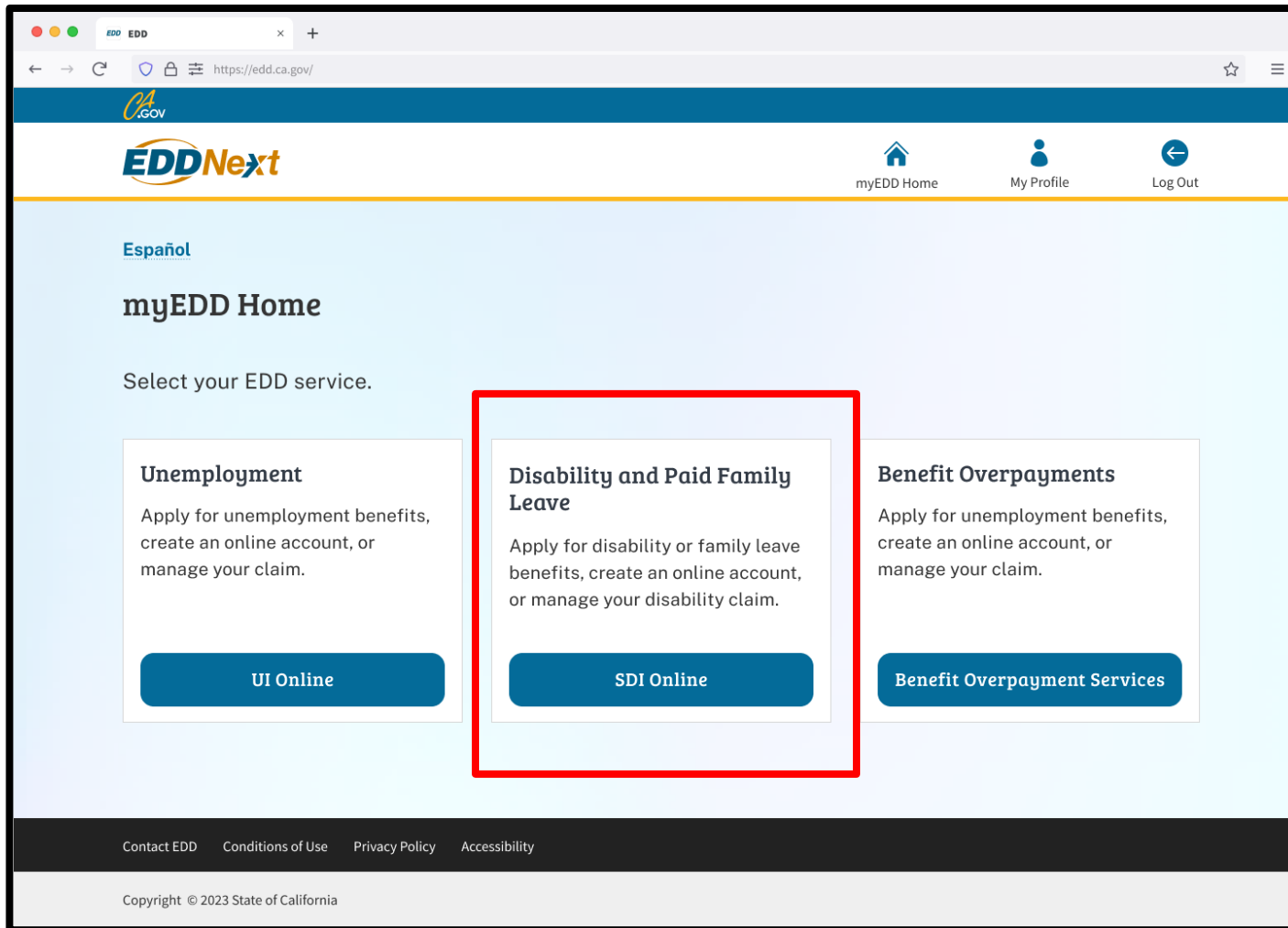
Select **Send Email**.

If you set up the login verification option as text message or phone call, follow the instructions based on that option.



Check your email for your verification code. This code expires in five minutes. Check your spam or junk folder if you do not get this email.

- Enter your verification code and select **Submit**.
- Select **resend the email** if you do not get a code.



Note

Select **Log Out** in the top right corner of any screen to exit your account.

From the myEDD homepage, select **SDI Online**.

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

If you are an authorized medical representative for multiple physicians/practitioners, you have the option to choose from a list of physicians/practitioners.

Select the licensed health professional's name under the Physician/Practitioner column to complete medical certifications on behalf of that licensed health professional.

You can only complete medical certifications for one physician/practitioner per log in. You must log out to select a different physician/practitioner.

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 be sent to the Physician/Practitioner homepage.

Review the following sections of this tutorial for instructions on submitting medical forms:

- [Submit a Claim for Disability Insurance \(DI\) Benefits \(DE 2501\) Part B](#)
- [Submit a Physician/Practitioner's Supplementary Certificate \(DE 2525XX\)](#)
- [Submit a Claim for Paid Family Leave \(PFL\) Benefits \(DE 2501F\) Part D](#)



Submit a *Claim for Disability Insurance (DI) Benefits* (DE 2501) – Part B

Learn more about how to submit the DE 2501
Part B – Physician/Practitioner's Certificate



Get Started

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

The Choose Physician/Practitioner screen only displays for medical representatives completing medical certifications on behalf of a licensed health professional. Physicians/practitioners should skip to the next page.

- On this screen, select the physician/practitioner which you are submitting the *Claim for Disability Insurance (DI) Benefits* (DE 2501), Part B on behalf.
- You can only select one physician/practitioner at a time.
- You can switch to a different physician/practitioner account by selecting **Log Out** and logging back into myEDD.

On the homepage, under the Search section, there are two ways to search for your patient's claim. Search by the patient's last name and one of the following:

- The patient's Receipt Number.
- The last four digits of the patient's Social Security number and date of birth.

To submit the Physician/Practitioner Certificate of the DE 2501 online, your patient must have already submitted Part A – Claimant's Statement of the DE 2501.

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: Claim ID

*Patient/PFL Last Name:

Date of Birth: (MMDDYYYY)

Cancel

Search

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
R100000000033667	Jane Doe	01-01-1990	Submit Physician/Practitioner Certificate

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

- The **Receipt Number** link allows you to review the information your patient submitted on the DE 2501, Part A – Claimant's Statement.
- Select **Submit Physician/Practitioner Certificate** under the Action column to proceed.

Note

The Submit Physician/Practitioner Certificate link is not available if the certificate was submitted by another user (e.g., your representative or another doctor). Review the [Submit a Physician/Practitioner's Supplementary Certificate \(DE 2525XX\)](#) section to extend a disability period for your patient.

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 screen, you can select the link to review the information your patient submitted to us.

Select **Next** to complete the medical certificate.

Note

Selecting **Cancel** at any time cancels the medical certificate and returns you to your homepage.

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
6600 BRUCEVILLE RD Sacramento, CA 95823-4671 United States	Select

Previous Cancel Not Found

On the Treatment Address screen, select the address where the patient is being treated.

Note

If the patient was treated at an address other than those shown, select **Not Found**.

Important

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

EDD Employment Development Department State of California

SSR Home About Drafts Profile

Initial Questions

1 Treatment Address 2 Patient Information 3 Claims Information 4 Declaration

You are currently on Step 2 Patient Information

* Indicates Required Field

Section 1 - Patient Information

Patient's Name: Harrison Jones
 Receipt Number: EL00000000000000000000
 Social Security Number:
 Date of Birth: (MM/DD/YYYY)
 File Number:

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 Number: (No dashes or spaces) 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: (MM/DD/YYYY)
 To: (MM/DD/YYYY)

*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: (MM/DD/YYYY)

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

Complete the following sections:

- Section 1 - Patient Information
- Section 2A – Physician/Practitioner Information
- Section 3 – Treatment Information

You must complete the fields marked with a red asterisk (*).

Select **Next** to continue.

Note

Select **Save as Draft** at any time to complete the form later.

Tip: Selecting **No** to “Are you presently treating the patient for this medical certificate?” ends your submission and makes your patient ineligible for benefits.

Claim Information



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: Select

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

ICD Diagnosis Code:

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)

Complete Section 4A - Claim Information.

You must complete the fields marked with a red asterisk (*).

You must provide the following information:

- Date disability began.
- Estimated return to work date (this may not be required for pregnancy or permanent disabilities).
- ICD codes and version.
- Diagnosis or detailed list of symptoms.

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)

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:

Date of discharge:

Section 4A Tip: Permanent Disability

If the patient's disability is diagnosed as permanent and you have selected the **permanent disability** box, you do **not** need to provide an estimated return to work date.

In the Findings field, enter 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:

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:

*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

Continue completing Section 4A - Claim Information.

You must complete the fields marked with a red asterisk (*).

Tip: Providing as much information as possible prevents claim processing delays and the need for us to reach out to you for additional details.

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:

Complete Section 5 – Pregnancy, if applicable.

Tip: Pregnancy-related disability claims

If the patient has not delivered, enter the number of days you expect the patient to be disabled postpartum for each delivery type (six weeks for vaginal delivery and eight weeks for cesarean delivery), instead of entering an estimated return to work date.

- Enter the Estimated Delivery Date.
- Enter the number 42 in the Vaginal Delivery field.
- Enter the number 56 in the Cesarean Delivery field.

Select **Next**.

ICD Code Summary



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	847	ICD-9	Sprains and Strains of Other and Unspecified Parts of Back	Delete

Previous

Cancel

Save as Draft

Next

Verify the ICD codes are correct.

If an ICD code is incorrect:

- Select **Delete**.
- Re-enter the correct code in the Claim Information section.

Select **Next** to continue.

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 – Prognosis Information and select **Next**.

Tip: Entering as much information as possible prevents claim processing delays and the need for us to contact you for additional details.

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

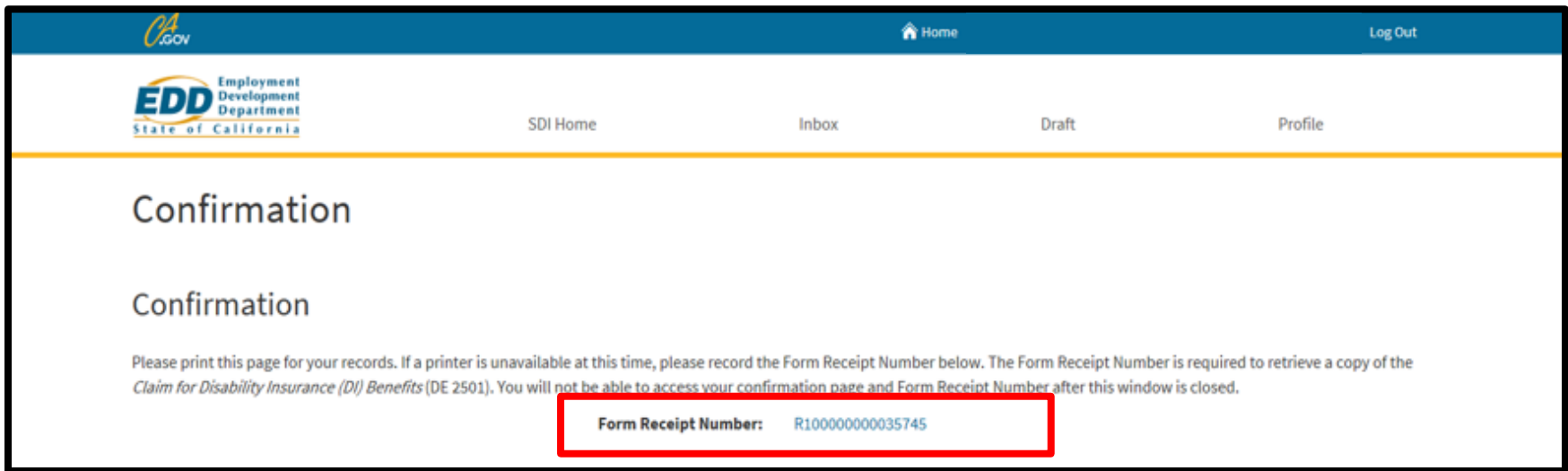
Submit

Select the check box in Section 7 - Certification to confirm the information you entered.

Review the information before you submit by selecting the **View the *Claim for Disability Insurance (DI) Benefits Physician/Practitioner Certification (DE 2501)*** link.

Note: You cannot modify the form after you select Submit.

Select **Submit**.

A screenshot of the EDD (Employment Development Department) Confirmation screen. The header includes the CA.GOV logo, a Home button, and a Log Out button. Below the header, the EDD logo and "State of California" are on the left, and navigation links for "SDI Home", "Inbox", "Draft", and "Profile" are on the right. The main content area has a "Confirmation" heading. Below it, a paragraph states: "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." At the bottom, a red-bordered box contains the text "Form Receipt Number: R100000000035745".

CA.GOV Home Log Out

EDD Employment Development Department State of California

SDI Home Inbox Draft 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: [R100000000035745](#)

On the Confirmation screen, your submission is assigned a Form Receipt Number.

- Save this Form Receipt Number. Your patient can request this number to prove the medical certificate was sent to us.
- Select the **Form Receipt Number** link to open a PDF printer-friendly version of the information you sent.

You have now completed Part B – Physician/Practitioner’s Certificate of your patient’s *Claim for Disability Insurance (DI) Benefits* (DE 2501) form. It can take up to 14 days to process your patient’s claim.



Submit a *Physician/Practitioner's Supplementary Certificate* (DE 2525XX)

Learn more about how to submit the DE 2525XX
and extend the disability period for your patient.



Get Started

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: Last 4 digits of SSN

*Patient/PFL Last Name: Doe

Date of Birth: MMDDYYYY

To submit a Physician/Practitioner's Supplemental Certificate from your SDI Online homepage:

- Select **Claim ID** or **Last four digits of SSN** from the Search By drop down menu.
- Enter the Claim ID or last four of the SSN for the patient.
- Enter the patient's last name.
- Enter the patient's date of birth (no dashes).

Select **Search** to continue.

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
DI-XXXX-XXX-XXX	Jane Doe	11-01-2018	Submit Additional Medical Information

Note

Claims must be approved to allow submission of additional medical information.

Verify the patient's information under the Claim(s) Available to Submit Additional Medical Information search results matches the patient's records.

- If they match, select the **Claim ID** link or the link provided in the Action column.
- If they do not match, return to the Search section, and try again.

Claim Summary

Claim Summary

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

Claim ID: **DI-XXXX-XXX-XXX**



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** form link.

Physician/Practitioner Supplementary Certificate (Part 1)

*Indicates Required Field

Section 1 - Physician/Practitioner Information

Names: **John Feelgood**

License Number: CA00000

Section 2 - Patient Information

Patient Name: **Jane Doe**

Date of Birth: **MM-DD-YYYY**

Social Security Number: XXX-XX-XXXX

Claim ID: DI-XXXX-XXX-XXX

Claim Effective Date: 11-01-2018

Section 3 - Form Information

Please complete and submit this information by the due date.

Issue Date:

Due Date:

The SDI Online system automatically populates certain portions of the application.


Review the following sections:

- Section 1 – Physician/Practitioner Information
- Section 2 – Patient Information
- Section 3 – Form 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:

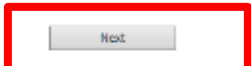
Diagnosis Code Version:

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?



Note

Selecting **No** to “Are you still treating this patient?” ends your submission and makes your patient ineligible for further benefits.

Complete Section 4A - Physician/Practitioner's Supplementary Certificate (Part 1).

You must complete the fields marked with a red asterisk (*).

Select **Next** to continue.

EDD

Employment
Development
Department

State of California

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:

(MM/DD/YYYY)

Date of Discharge:

(MM/DD/YYYY)

☐ 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:

(MM/DD/YYYY)

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

ICD Procedure Code:

Procedure Code Version:

Select

ICD Procedure Code:

Procedure Code Version:

Select

ICD Procedure Code:

Procedure Code Version:

Select

ICD Procedure Code:

Procedure Code Version:

Select

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:

(MM/DD/YYYY)

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

Cancel

Save as Draft

Next

Complete Section 4B - Physician/Practitioner Supplementary Certificate (Part 2).

You must complete the fields marked with a red asterisk (*).

Select **Next** to continue.

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 screen:

- Select the patient's treatment address from the Action column.
- If the patient was treated at an address other than those listed, select **Not Found**.

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

Select the check box in Section 5 – Certification.

Note: You cannot modify the form after you select Submit.

Select **Submit** to complete your form.

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:

- Save the Form Receipt Number for your records. Your patient can request this number to prove the medical certificate was sent to us.
- Select the **Form Receipt Number** link to open a PDF printer-friendly version of the information you sent.

You have now completed the *Physician/Practitioner's Supplementary Certificate* (DE 2525XX) to extend your patient's disability benefits. Allow up to 10 days for the EDD to process this form.



Submit a *Claim for Paid Family Leave (PFL) Benefits* (DE 2501F) – Part D

Learn more about how to submit the DE 2501F
Part D – Physician/Practitioner's Certification



Get Started

Home

*Indicates Required Field

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 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

From your homepage, use the Search section to look up Part D - Physician/Practitioner's Certification of the DE 2510F form.

Search by:

- The **Patient/PFL Receipt Number**.
- Enter the Receipt Number (provided by the individual filing for benefits) and their last name.
- Select **Search**.

Note

To submit Part D of the *Claim for Paid Family Leave (PFL) Benefits* (DE 2501F) online, your patient's caregiver must have submitted Part A of the DE 2501F online.

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

Note

Select **Cancel** at any time to cancel the claim and return to your homepage.

In the View Claimant DE 2501F section:

- Select the **View Claim for Paid Family Leave (PFL) Benefits (DE 2501F) for Care** link to review the claimant's section of the form.
- Select **Next** to complete the certificate.

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
1000 Main St San Francisco, CA 94115 United States	Select

Previous

Cancel

Not Found

On the Treatment Address screen:

- Select your patient's treatment address from the Action column.
- If the patient was treated at an address other than those listed, select **Not Found**.

Initial Questions



Treatment Address



Initial Questions



Medical Information



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

Claimant Social Security Number: XXX-XX-XXXX

Patient (Care Recipient) Name: John Johnson

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

The SDI Online system automatically populates certain sections of the application.

Complete the Physician/Practitioner Information section.

You must complete the fields marked with a red asterisk (*).

Select **Next** to proceed.

Note

Select **Save as Draft** at any time to complete the form later.

Select **Previous** to return to the previous screen.

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:

Previous

Cancel

Save as Draft

Next

Complete the Medical Information section.

You must provide the following information:

- Valid ICD codes.
- Diagnosis or detailed list of symptoms.
- First date care is needed.
- Estimated date care is no longer needed.
- Hours your patient will require care each day.

You must complete the fields marked with a red asterisk (*).

Select **Next**.

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 detrimental to your patient? ☐ Yes ☐ No

Certification

☐ 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.

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

Cancel

Save as Draft

Submit

In the Certification section:

- Select the check box to confirm the information you entered.
- Select **View Claim for Paid Family Leave (PFL) Benefits (DE 2501F) for Care** to review the information you entered.
- **Note:** You cannot modify the form after you select Submit.
- Select **Submit**.

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:

- Save the Form Receipt Number for your records. The individual filing for benefits can request this number to prove the medical certificate was submitted to us.
- Select the **Form Receipt Number** link to open a PDF printer-friendly version of the information you submitted.

You have now completed Part D - Physician/Practitioner's Certificate of the *Claim for Paid Family Leave (PFL) Benefits* (DE 2501F) for the caregiver's Paid Family Leave care claim. Allow up to 14 days to process this form.



Complete Paper Claim Forms

Learn more about how to complete and submit a paper claim form for disability or family leave benefits.



[Get Started](#)

Common situations that require individuals to apply by paper form:

It is strongly recommended that you complete a paper *Claim for Disability Insurance (DI) Benefits* (DE 2501), Part B form when your patient applies by paper form. Submitting all forms together helps prevent errors and reduces processing time.

Patients/Claimants:

- Who are undocumented workers
- Without a valid California Driver's license or California identification card
- Name exceeds SDI Online character limitation

Health Professionals:

- Licensed out of state
- Licensed out of country
- Working in facilities
- Who are religious practitioners
- Name exceeds SDI Online character limitation

To avoid processing delays when completing a paper claim form:

Do

- Use black ink only.
- Type or write clearly **within** the boxes provided.
- Mail the completed form in the pre-addressed envelope provided.

Don't

- Do not send photocopied or faxed forms.
- Do not mail the paper form if you previously submitted it online.



SAMPLE, this page for reference only

Application for Disability Insurance Benefits

Health Insurance Portability and Accountability Act (HIPAA) Authorization

Social Security Number 0000000000

Claimant Name (First) (MI) (Last)
Sample Claimant

I authorize

Geoff Booker

(Person or 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 or managers and any other EDD employee who may need to access this information in order to process my claim or determine eligibility for State Disability Insurance benefits.

I understand that the EDD is not a health plan or health care provider, so the information released to the EDD may no longer be protected by federal privacy regulations (45 CFR Section 164.508(c)(2)(iii)). The 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 15 years from the date received by the 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 the 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 01252025

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

The Health Insurance Portability and Accountability (HIPAA) Authorization must be completed and signed by the individual filing for disability benefits (page 1).

Part A - Claimant's Statement is completed by the individual filing for disability benefits (pages 1-4).

SAMPLE, this page for reference only

**Application for Disability Insurance (DI) Benefits –
Physician or Practitioner's Certificate**

Print with black ink.

Part B - Physician or Practitioner's Certificate	
B1. Patient's Social Security Number	0 0 0 0 0 0 0 0 0 0
B2. Patient's file number	6 9 - 6 4 2 - 3 8
B3. If you know the patient's electronic receipt number, enter it here:	B4. Patient's date of birth
R	0 1 0 1 1 9 0 0
B5. Patient's name (First) (MI) (Last)	
S a m p l e C l a i m a n t	
B6. Physician or Practitioner's license number	B7. State or country (if not U.S.A.) that issued license number entered in B6
6 3 4 - 0 2 7 9 3 0	State CA Country
B8. Physician or Practitioner license type	B9. Specialty (any)
MD	
B10. Physician or Practitioner's name as shown on license (First) (MI) (Last) Suffix	
G e o f f B o o k e r	
B11. Physician or Practitioner's address	
Mailing Address, PO Box or Number, Street, Suite#	
2 6 9 C o m m e r c e	
City	State Zip or Postal Code Country (if not U.S.A.)
A n y w h e r e	CA 7 2 6 9 4
County Hospital or Government Facility address	
Facility Name (if applicable)	
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	To
0 1 2 5 2 0 2 5	0 1 2 5 2 0 2 5
<input checked="" type="checkbox"/> Check here to indicate you are still treating the patient	
At intervals of: <input type="checkbox"/> Daily <input type="checkbox"/> Weekly <input checked="" type="checkbox"/> Monthly <input type="checkbox"/> As Needed <input type="checkbox"/> Other	
B13. At any time during your attendance for this medical problem, has the patient been incapable of performing their regular or customary work?	
<input checked="" type="checkbox"/> Yes - enter date disability began 0 1 2 5 2 0 2 5	
No - skip to B13	
Was the disability caused by an accident or trauma? <input type="checkbox"/> Yes <input type="checkbox"/> No	
If yes, indicate the date the accident or trauma occurred.	
B14. Date you released or anticipate releasing patient to return to their regular or customary work ("unknown", "indefinite", etc., not acceptable)	
M M D D Y Y Y Y	
<input type="checkbox"/> Check here to indicate patient's disability is permanent and you never anticipate releasing patient to return to their 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: M M D D Y Y Y Y Date pregnancy ended: M M D D Y Y Y Y	
Type of delivery, if patient has delivered: <input type="checkbox"/> vaginal <input type="checkbox"/> cesarean	

Part B - Physician's/Practitioner's Certificate (pages 5-7).

As the physician/practitioner, you must complete all applicable information, including:

- Care and treatment dates.
- Date disability began.
- Estimated return to work date.
- Diagnosis or a list of symptoms.
- ICD codes.
- In the case of pregnancy, the estimated delivery date and number of days for recovery per delivery type (42/56) or the pregnancy end date and delivery type.
- License and personal information.
- Your signature.

Note

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.

SAMPLE, this page for reference only



Application for Paid Family Leave Benefits

Part A - Statement of Claimant (Care, Bonding, Or Military Assist Provider)			
A1. Your Social Security Number 0000000000		A2. Your date of birth MMDDYYYY	
A3. Language you prefer to use <input checked="" type="checkbox"/> English <input type="checkbox"/> Spanish <input type="checkbox"/> Other		A4. Your Legal Name First Name MI Last Name Sample Claimant	
A5. Gender Identity <input type="checkbox"/> Male <input checked="" type="checkbox"/> Female		A6. Phone Number 123 456 7890	
A7. If you have worked under any other last names, enter them here (for example, a maiden name or chosen name)			
A8. Mailing Address (to receive mail at a private mail box—not a U.S. Postal Service box—you must include the number in the "PMB# (if applicable)" space.) City: 123 Any Street State/Prov.: CA Zip or Postal Code: 12345 Country (if not U.S.A.):			
A9. Name of your Employer Mailing Address Roadrunner Pastries 647 Armistice Way City: Cityname State/Prov.: CA Zip or Postal Code: 12345 Employer's Phone Number: 555 123 4567			
A10. Last day you worked MMDDYYYY		A11. Date you want your PFL claim to start MMDDYYYY	
A12. Date you returned or will return to work MMDDYYYY		A13. Did you work or will you continue to work during your family leave period? <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	
A14. Why did you or will you reduce your work hours or stop working? Care for family member <input checked="" type="checkbox"/> Bond with child <input type="checkbox"/> Military Service <input type="checkbox"/> Other (explain)		A15. What is your usual occupation? Pastry Chef	
A16. Select your preferred payment method <input checked="" type="checkbox"/> Debit Card <input type="checkbox"/> Check		A17. Family Member's Legal Name First Name MI Last Name (This is the person you are caring for or bonding with, or your military family member) Cookie Claimant	
A18. This family member is your: Child <input checked="" type="checkbox"/> Spouse <input type="checkbox"/> Regional Domestic Partner <input type="checkbox"/> Parent <input type="checkbox"/> Parent-In-Law <input type="checkbox"/> Grand Parent <input type="checkbox"/> Grand Child <input type="checkbox"/> Sibling <input type="checkbox"/> Other (explain)			
A19. Is any other family member ready, willing, and able and available to provide care for the same period you are claiming PFL Benefits? No <input checked="" type="checkbox"/> Yes <input type="checkbox"/>		A20. Have you claimed or do you plan to claim workers' compensation benefits for any portion of the period covered by this claim? No <input checked="" type="checkbox"/> Yes <input type="checkbox"/>	
A21. Do you have more than one employer? No <input checked="" type="checkbox"/> Yes <input type="checkbox"/>		A22. If your employer(s) continued or will continue to pay you during your family leave, indicate type of pay: Sick <input type="checkbox"/> Vacation <input type="checkbox"/> Other (explain)	
A23. May we disclose benefit payment information to your employer(s)? No <input type="checkbox"/> Yes <input checked="" type="checkbox"/>		A24. At any time during your PFL leave, were you in the custody of law enforcement authorities because you were convicted of violating a law or ordinance? No <input checked="" type="checkbox"/> Yes <input type="checkbox"/>	
A25. Declaration and signature. By my signature on this application statement, I (1) claim Paid Family Leave Benefits and certify that throughout the period covered by this application I was providing care for, bonding with, or participating in a qualifying event with the recipient named above (2) authorize EDD to release my personal information as shown on this application to the care recipient's treating physician as they are respectively listed in Part C and Part D of this application (3) authorize my employer(s) to disclose EDD all facts concerning my employment that are within their knowledge and (4) authorize release and use of information as stated in the information collection and access portion of this form. 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 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 application statement are granted for a period of 15 years from the date of my signature or the effective date of the application, whichever is later.			
Claimant's Signature (do not print) Sample Claimant		If signature is made by mark (X), please place mark here: 01252025	
*If your signature is made by mark (X), it must be attested by two witnesses with their addresses			
1 st Witness Signature and Address		2 nd Witness Signature and Address	

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

Page 1: Part A - Statement of Claimant:

The individual filing for benefits must complete all applicable information, including:

- Personal Information
- Last day worked
- Date the family leave began
- Employer information
- Signature

Part A is required for all claim types:

- Bonding
- Care
- Military Assist

SAMPLE, this page for reference only

Part B – Bonding Certification (to be completed by person claiming PFI benefits to bond with a child)											
B1. Your Social Security Number				B2. Date of foster care or adoption placement				B3. Child named in B3 is my			
0000000000				MM/YY				<input checked="" type="checkbox"/> Biological Child <input type="checkbox"/> Stepchild <input type="checkbox"/> Foster Child <input type="checkbox"/> Adopted Child <input type="checkbox"/> Other			
B4. Your Legal Last Name (needed in case pages of this claim become separated)				B5. Child's Social Security Number (if available)				B6. Child's date of birth			
claimant								12/01/2024			
B7. Child's Gender Identity				B8. Legal Name of Child First Name				B9. Address where the child lives (if different from claimant's)			
Male <input type="checkbox"/> Female <input checked="" type="checkbox"/>				Cookie				City: State/Prov.: Zip or Postal Code: Country (if not U.S.A.):			
B10. As evidence of the relationship in B3, check <u>one</u> 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"/> Independent adoption placement agreement, AD-924 <input type="checkbox"/> Declaration of paternity, CS-909 <input type="checkbox"/> Other <input type="checkbox"/> Adoptive placement agreement, AD-907											
B11. Declaration and signature. By my signature on this bonding certification, I authorize the medical provider, adoption agency, adoption parties, 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 15 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								Date Signed Sample Claimant 01/25/2025			
Part C – Statement of Family Member Receiving Care											
May be completed by claimant if the family member receiving care is mentally or physically unable to do so. Must be signed by the family member receiving care or their authorized representative.											
C1. Date of Birth of Family Member Receiving Care				C2. Phone Number of Family Member Receiving Care				C3. Gender Identity of Family Member Receiving Care			
MM/YY								Male <input type="checkbox"/> Female <input type="checkbox"/>			
C4. Legal Name of Family Member Receiving Care First Name MI Last Name											
C5. Address of Family Member Receiving Care City: State/Prov.: Zip or Postal Code: Country (if not U.S.A.):											
C6. Confirmation of medical disclosure authorization. I authorize my Physician/practitioner to disclose my current personal health information to my care provider and to the California Employment Development Department (EDD). I further understand that copies of my signature below are as valid as the original.											
Signature of Family Member Receiving Care (Do Not Print)								Date Signed			
								MM/YY			
C7. Authorized Representative signing on behalf of family member receiving care must complete the following I _____, represent the family member receiving care or bonding 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, contact EDD).											
Authorized Representative's Signature (Do Not Print)								Date Signed			
								MM/YY			

Page 2:

Part B – Bonding Certification:

- For bonding claims only. The individual filing for benefits must complete all bonding information and sign the form.

Part C – Statement of Care Recipient:

- For care claims only. Your patient/care recipient or the individual filing for benefits must fill out the appropriate care information. The care recipient or their authorized representative must sign the form.

The individual filing for benefits completes either Part B or Part C – but never both.

Note: Part B and Part C are not needed for military assist claims.

SAMPLE, this page for reference only

Medical certifications must be completed by a licensed Physician or Practitioner authorized to certify in a patient's disability or serious health condition pursuant to California Unemployment Insurance Code Section 2700.

Instructions for completing this form:

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 or participating in a qualifying event.)

D1. P1L claimant's (care provider's) Social Security Number	D2. P1L claimant's name First Name MI Last Name	
D3. Patient's date of birth	D4. Does your patient require care by the claimant? No skip to D10 Yes	
D5. Patient's Name First Name MI Last Name	D6. Diagnosis or, if not yet determined, a detailed statement of symptoms	
D7. Primary ICD Code	D8. Secondary ICD Codes	D9. Date when the patient's condition started
D10. First date patient needed care	D11. Date you expect patient to recover NEVER	D12. Date you estimate patient will no longer need care by the claimant PERMANENT
D13. Approximately how many total hours per day will the patient need the claimant for care? 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 Name MI Last Name		
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 2700.		
Original Signature of Attending Physician/Practitioner – rubber stamp is not acceptable	Physician/Practitioner's Phone Number	Date Signed

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.

Page 3: Part D – Physician/Practitioner's Certification

As the physician/practitioner, you must complete all applicable information for care claims, including:

- Date disability began.
- First date care was needed.
- Date you expect recovery.
- Number of hours per day care is required.
- Diagnosis or a list of symptoms.
- ICD codes.
- Your information and license.
- Signature.

Note

Part D is not needed for bonding or military assist claims.

SAMPLE, this page for reference only

Part E – Military Assist Certification (To be completed by the claimant.)	
E1. Your Social Security Number	E3. Your Legal Name First Name MI Last Name
E3. Name of military member on covered active duty or impending call to covered active duty status (First Name MI Last Name)	
E4. Military Member's Date of Birth	E5. Military Member's Gender Identity <input type="checkbox"/> Male <input type="checkbox"/> Female
E6. Military Member's Mailing Address	
City State/Prov. Zip or Postal Code Country (if not U.S.A.)	
E7. Last four digits of military member's Social Security Number	
E8. Period of military member's covered active duty TO	E9. Date military member was notified of covered active duty
E10. Select one of the following and attach the indicated document to support that the military member is on covered active duty or impending call or order to covered active duty status <input type="checkbox"/> Covered Active Duty Orders <input type="checkbox"/> Letter of Impending Call or Order to Covered Duty <input type="checkbox"/> Documentation of Military Leave Signed by the Approving Authority for Military Member's Rest and Recuperation	
E11. The qualifying event for the PFL claim is for (One or more reasons may be selected) <input type="checkbox"/> Provide or arrange childcare for military member's child <input type="checkbox"/> Provide or arrange care for military member's parent <input type="checkbox"/> Attend counseling <input type="checkbox"/> Make financial or legal arrangements <input type="checkbox"/> Assist military member during rest and recuperation leave <input type="checkbox"/> Attend military event <input type="checkbox"/> Represent military member at federal, state, or local agencies <input type="checkbox"/> Address issues due to military member's death <input type="checkbox"/> Other:	
E12. Written documentation supporting this request for leave is available and attached <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> None Available Note: A complete and sufficient certification to support a request for PFL leave due to a qualifying event includes any available written documentation that supports the need for leave. Documentation may include: a copy of a meeting announcement for informational briefings sponsored by the military; a document confirming the military member's Rest and Recuperation leave; an appointment with a third party (i.e., a counselor, school official, or staff at a care facility); or a copy of a bill for services for the handling of legal or financial affairs. If leave is requested to meet with a third party, the employee must provide the supporting documentation of the meeting that includes the name, address, and appropriate contact information of the individual or entity with whom you are meeting (i.e., either phone number, fax number, or email address of the individual or entity).	
E13. Declaration and Signature. By my signature on this military assist certification, 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 statements, 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 15 years from the date of my signature or the effective date of the claim, whichever is later.	
Original Signature of Military Assist Claimant (Do Not Print)	Date Signed

Page 4: Part E – Military Assist Certification

The individual filing for benefits must complete all information for military assist claims, including:

- The military member's personal information.
- Dates of covered duty.
- Qualifying event information.
- Signature.

Note

Part E is not needed for bonding or care claims. It is only for military assist claims.

SAMPLE, this page for reference only

Qualifying Event for Leave – Documentation

If leave is requested to meet with a third party, the employee must provide supporting documentation of the meeting that includes the name, address, and appropriate contact information of the individual or entity with whom you are meeting (i.e., either the phone number, fax number or email address of the individual or entity). The reason for a meeting can include: arranging for child or parental care, counseling, making financial or legal arrangements, acting as the military member's representative before a federal, state or local agency for purposes of obtaining, arranging or appealing military service benefits, or attending any event sponsored by the military or military service organizations.

Please submit supporting documentation, if applicable.

Attach an additional sheet if more space is required.

Your Social Security Number	Your Legal Name First Name	MI	Last Name
Name of individual with whom claimant is meeting: _____			
Title: _____			
Organization: _____			
Phone Number (provide area or country code): _____			
Fax Number (provide area or country code): _____			
Email Address: _____			
Mailing Address			
City	State/Prov.	Zip or Postal Code	Country (if not U.S.A.)
Describe nature of meeting, include dates, if known:			

Page 5: Qualifying Event for Leave Documentation

Military assist claims to meet with a third party must have supporting documentation that includes contact information for the third party and a description of the event with dates.

Individuals should make sure all pages are completed and all signatures are obtained before the claim is mailed to us for processing.

Note

The Qualifying Event for Leave Documentation is not needed for bonding or care claims.

CONTACT US

1-855-342-3645

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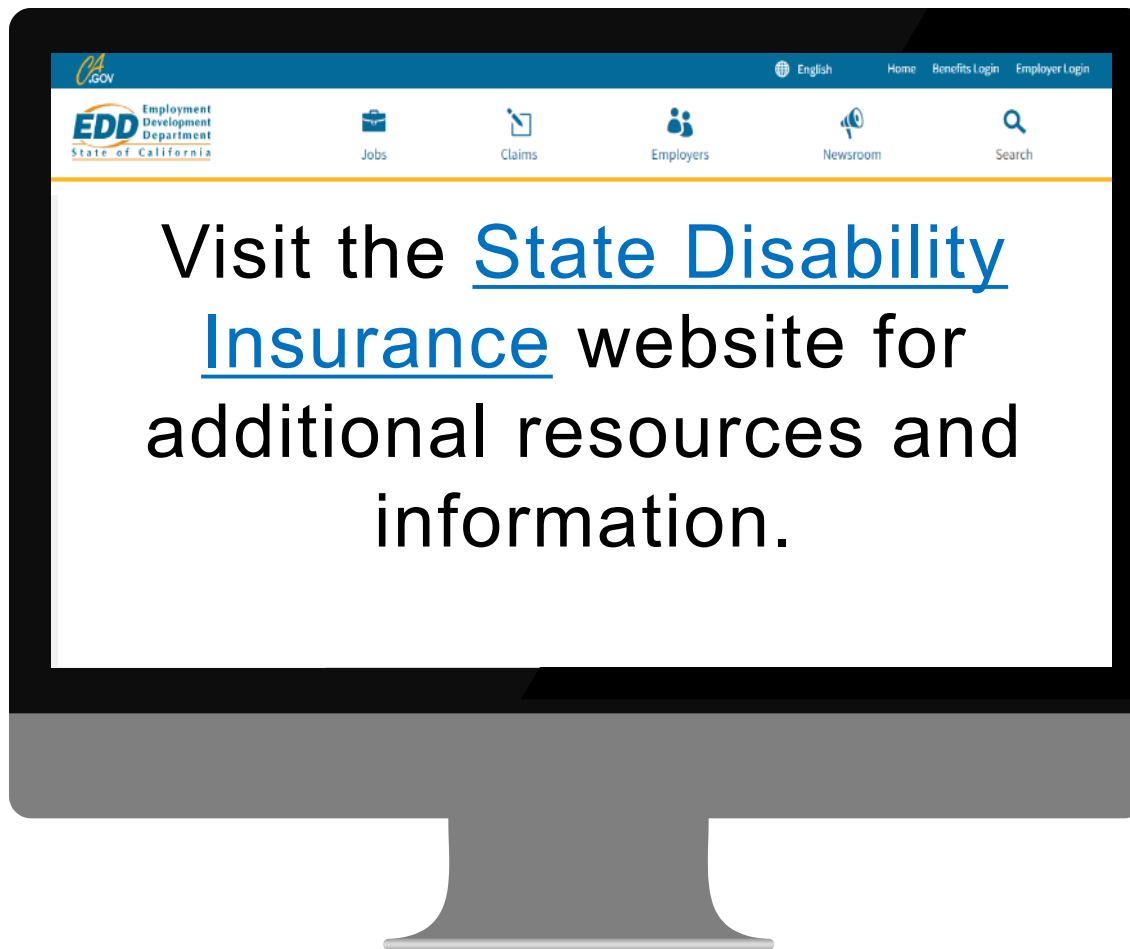
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