

MATERNITY LEAVE REQUEST FORM

Copies must be completed and filed with Building Principal(s) and the Superintendent prior to the end of the second trimester.

DATE _____

EMPLOYEE NAME _____

AMOUNT OF LEAVE TIME REQUESTED:

1. Will you need to apply to the Sick Leave Bank for additional days beyond your accumulated sick days? YES OR NO
2. If yes, how many days will you apply for? _____
3. Name of Physician/Obstetrician _____

I, the undersigned, believe all information above to be true to the best of my knowledge and agree to the above requested leave status.

Signature of Employee _____ Date _____

4. Approximate date of delivery _____
5. Signature of Physician/Obstetrician _____
6. Office Address _____
7. Office Phone _____

THIS FORM MAY BE REVISED AND RESUBMITTED AS MEDICALLY NECESSARY (not to exceed thirty (30) days) DURING THE THIRD TRIMESTER AND/OR UPON DELIVERY.