



3-WEEK MATERNITY LEAVE FORM

Name: _____

Employee ID: _____

Worksite: _____

Certificated

Classified

Job Title: _____

For more

information regarding this benefit, please refer to the 3-Week Maternity Leave Fact sheet.

DIRECTIONS: Select one of the options below and submit all copies of the completed form to your immediate supervisor within (30) thirty days of delivery.

TO BE COMPLETED BY EMPLOYEE (I certify under penalty of perjury that the foregoing, including all attachments, is true and correct.)

Maternity Leave Time:

Date of Birth: _____ (please attach birth certificate)

Please apply my three (3) weeks of paid maternity leave during the first three (3) weeks of post-partum.

Please apply my three (3) weeks of paid maternity leave in one-week increments after the birth of my child.

First Day of Leave: _____ Last Day of Leave: _____

Total Days: _____

If leave is being requested in one-week increments, please complete separate A-94 form for each week of leave.

Note: The 3-week Maternity Leave benefit runs concurrently with Pregnancy Disability/Parental Leave (Baby Bonding).

Remarks:

Employee Signature: _____ Date: _____

ACKNOWLEDGEMENT SIGNATURES

Immediate Supervisor:

Signature: _____ Date: _____

Payroll Supervisor:

Signature: _____