A-94
Pers 5/19

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: