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. 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.

_____ **I have read Article V.L., "Maternity Leave," in the Master Agreement.**
(initial)

Signature of Employee ____________________________________ Date _________

2. Approximate date of delivery ______________________________________
3. Signature of Physician/Obstetrician ________________________________
4. Office Address ____
5. 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.