

### 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: \_\_\_\_\_