Webster Parish School Board

REQUEST FOR MATERNITY LEAVE

SOCIAL SECURITY NUMBER_____DATE _____

NAME_____

SCHOOL _____

IF TEACHER, WHAT GRADE AND/OR SUBJECT(S)_____

THE EXPECTED DATE OF BIRTH OF MY CHILD IS_____

I AM REQUESTING MATERNITY LEAVE TO BEGIN AT THE CLOSE OF THE SCHOOL DAY ON

_____ ESTIMATED NUMBER OF WEEKS_____
LAST DAY TO WORK

I EXPECT TO RETURN TO WORK ON_____

THE PERIOD OF DISABILITY FOR MATERNITY IS **6-8 WEEKS** FROM THE TIME OF DELIVERY. 6 WEEKS FOR NORMAL DELIVERY AND 8 WEEKS FOR CESEARAN DELIVERY. **(THIS INCLUDES HOLIDAY WEEKS ALSO**). ADDITIONAL TIME MUST BE MEDICALLY NECESSARY AND STATED IN WRITING FROM A PHYSICIAN. REMEMBER A MEDICAL RELEASE TO RETURN TO WORK FROM YOUR PHYSICIAN MUST BE SUBMITTED BEFORE RETURNING.

_____
EMPLOYEE'S SIGNATURE

_____
PRINCIPAL/SUPERVISOR'S SIGNATURE

THIS PORTION TO BE COMPLETED BY YOUR PHYSICIAN

THIS IS TO CERTIFY THAT THE ABOVE NAMED PATIENT IS PREGNANT. SHE WILL BE CONFINED BY

CHILDBIRTH AND UNABLE TO WORK FROM _____ TO _____.

THE EXPECTED DATE OF THE BIRTH OF HER CHILD IS _____.

_____ _ _____
PHYSICIAN'S SIGNATURE ADDRESS

_____ _____
PLEASE TYPE OR PRINT NAME TELEPHONE NUMBER