

IBERIA PARISH SCHOOL BOARD

MATERNITY LEAVE PROCEDURES

(Effective: October 1, 2012)

1. Maternity leaves are granted for six (6) or eight (8) weeks depending on the type of delivery: (6 weeks for vaginal; 8 weeks for cesarean)
2. Maternity leave begins the day the baby is born.
3. Once the maternity leave has ended (6 or 8 weeks), the employee may apply for a **Family and Medical Leave (FMLA)** for a maximum of 12 weeks. (FMLA is leave **without pay**.) The 12 weeks include the 6-8 weeks of maternity leave already taken.
4. Except for emergency situations, the employee shall submit to the Personnel Office, a **Request for Maternity Leave Form** 30 days PRIOR to the start of the leave.
5. Anytime the employee is out **BEFORE** the baby is born, she will use:
 - a. Accumulated sick days
 - b. Extended sick leave (The doctor **MUST** complete a **Physician's Certificate of Medical Necessity for Extended Medical Leave Form.**)
 - c. Leave without pay
6. The doctor must complete a **Doctor's Statement for Maternity Leave Form** and mail it to the Personnel Office as soon as possible after the baby is born.
7. All doctor's statements **MUST** be sent to: 1) Personnel Department 2) School Secretary 3) Dena Louviere in the Business Office by the **LAST DAY of the month in which the absence occurs** *otherwise you will be docked 100% of your daily rate of pay for each day you are out. THERE WILL BE NO REFUNDS GIVEN IF DOCTOR'S STATEMENTS ARE TURNED IN AFTER THE MONTH HAS ENDED.*

Maternity Leave to Do List

1. Contact Mrs. Gwen Antoine at 337-365-2341 or email her (gwantoine@iberia.k12.la.us) to request a **Maternity Leave Packet**.
2. Bring the **Request for Maternity Leave** back to Mrs. Antoine at the school board office and then complete the rest of your paper work.
3. When you are no longer able to work, get a **doctor's statement** that puts you on **Emergency Leave or Extended Leave**. Include the date that your leave is to begin. Forms may be downloaded from the website located under **Forms**.
4. **When the baby is born**, your doctor needs to complete and mail to me, the **Doctor's Statement for Maternity Leave** which is included in this packet. When you have delivered, call or email me to let me know to process your paperwork. Your **"Maternity Leave"** starts the day you give birth (6 weeks/vaginal; 8 weeks/cesarean).
5. **When your doctor releases you to return to work**, he or she needs to prepare a statement of release including the date you can return to work. This release **must be brought** to Mrs. Antoine so that the necessary paper work can be completed at the central office in order for you to return to work. You should not go back on campus before that. **A sample copy is attached**.
6. **If you carry disability insurance**, contact Linsey Garcia for information regarding it. Both you and your doctor are responsible for completing your respective sections. When the packet is completely and correctly filled out, bring it (intact) to Dena Louviere at the school board office for review and final completion. Dena will mail the packet back to you, or you may opt to pick it up when complete. It is your responsibility to mail the packet to your insurance company.

FYI: What does "Maternity Leave" really mean?

Maternity leave is simply an amount of time granted to you to care for your newborn.

When you are on maternity leave, you will receive 100% of your gross monthly salary **as long as you have accumulated sick days to use**. Once these days are **exhausted**, you will use your extended sick leave days, which means you will receive 65% of your gross monthly salary for up to 30 days (for maternity leave). (Refer to #3 and #4 of **IPSB Maternity Leave Procedures**.)

What is Emergency Leave?

Emergency leave is **your accumulated sick days**. All sick and vacation days must be exhausted **BEFORE** can use ANY extended sick leave days.

REQUEST FOR MATERNITY LEAVE

Medical Certification That Pregnant Employee is Able to Continue in Her Position

This will certify that _____, who teaches _____ (grade) and _____ (subject) at _____ (school/site), because of her physical condition, can continue in her job until _____ (date), which is _____ (days) prior to the expected date of the birth of her unborn child. Without any complications she should be able to return to work on _____ (date).

Additional Remarks: _____

Signature of Attending Physician: _____

Certification by Teacher of Number of Accumulated Sick Days to be Used before Going on Maternity Leave

On the date specified above, I will be taking time off for the birth of my unborn child. On that date, I will have _____ (days) of accumulated sick leave. I plan to use _____ (days) of this time as sick leave understanding that when I have used all of my accumulated days or the number of days indicated, I will automatically go on **Extended Sick Leave**. I also realize that it will be my obligation to continue my premium payments if I wish my insurance coverage to continue while I am on maternity leave, or to cancel in writing to the Payroll Department; otherwise my insurance will automatically be cancelled the last day of the month that my leave becomes effective.

Additional Remarks: _____

Signature of Teacher: _____

Acknowledgement of Above Information for Certification by Administrator

I have reviewed the above information that _____ (teacher) at _____ (school/site) will leave her position at the end of the school day on _____ (date) and will return to her position barring any complications on _____ (date).

I also understand she will spend _____ (days) on sick leave before officially going on maternity leave. I will advise the Personnel Director the day that the teacher returns to work.

A RELEASE FORM WITH PROPER PHYSICIAN'S STATEMENT MUST BE OBTAINED FROM THE PERSONNEL DEPARTMENT PRIOR TO RETURNING TO WORK.

Signature of Administrator: _____

IBERIA PARISH SCHOOL BOARD
PERSONNEL DEPARTMENT
P. O. Box 200 New Iberia, LA 70562

DOCTOR'S STATEMENT FOR MATERNITY LEAVE

(This section is to be completed by employee)

Employee's Name: _____

Employee I.D. Number: _____

Address: _____

Phone Number: _____

School/Site Location: _____

Position: _____

If Teacher, Grade and/or Subject: _____

This Section is to Be Completed by Physician's Office

Date of Delivery: _____

Method of Delivery: **Vaginal** **Cesarean**

Physician's Signature: _____

Date Signed: _____

Iberia Parish School Board

Mail To:
P. O. Box 200
New Iberia, LA 70562

Director of Human Resources
Telephone: (337) 365-2341 FAX (337) 365-6996

Employee: _____ School: _____
Address: _____ Position: _____
Phone: _____

Employee Number: _____

PHYSICIAN'S CERTIFICATE OF MEDICAL NECESSITY FOR EMERGENCY and EXTENDED MEDICAL LEAVE Form must be filled out COMPLETELY.

Patient's Full Name: _____

EXACT period for which extended leave is requested: _____

Name and Complete Address of Physician: _____ (MM/DD/YY) TO _____ (MM/DD/YY)

Physician's Phone Number: _____

I, _____ a Louisiana licensed physician, have personally examined _____ an employee/or immediate family member (spouse, parent or child) of an Employee of the Iberia Parish School Board (IPSB). It is my professional opinion submitted under the penalty of false swearing as found in Louisiana Revised Statutes 17:1202 Louisiana Revised Statutes 14:125 that the above named IPSB employee, is in need of at least ten (10) consecutive days of leave from work for a medical necessity defined in the statutes as a result of catastrophic illness or injury which means a life-threatening, chronic or incapacitating condition of himself/herself or an immediate family member.

I further affirm pursuant to Louisiana Revised Statutes that the above is my medical opinion formed after having personally examined the above named IPSB employee or immediate family member. My last examination of this patient occurred on: _____

The above name IPSB employee may return to work on _____ without restrictions.

Or

Alternatively, the above named IPSB employee may return to work on _____ if provided with
The following accommodation/restrictions: **NOTE: A definite return date or estimated date must be provided.**

Current Diagnosis: (Must be legible and detailed)

Based on the information provided, the diagnosis of the applicant and his/her immediate family member is:

A. Life Threatening

B. Chronic

C. Incapacitating Condition

ONE OR MORE MUST BE CIRCLED.

The Following Must Be Completed:

List the specific life threatening, chronic, or incapacitating symptoms that the patient is currently experiencing that prevents him/her from returning to work at this time (Attach additional comments if necessary.)

Physician's Signature

(Original Signature Only - No Facsimile Allowed)

Date

MAIL THIS FORM DIRECTLY TO:

Iberia Parish School Board - Personnel Department
P.O. Box 200
New Iberia, LA 70562

FOR SCHOOL BOARD USE ONLY:

DATES APPROVED BY SUPERINTENDENT OR DESIGNEE:

Signed: _____
Date: _____

NOTE: IPSB EMPLOYEES MUST SUBMIT A COPY OF THIS FORM TO THE SCHOOL SECRETARY, BUT THE ORIGINAL MUST BE MAILED DIRECTLY TO THE PERSONNEL DEPARTMENT.

EMPLOYEE RETURN TO WORK RELEASE

This form **MUST** be completed **BEFORE** you can return to your work place.

DATE:

NAME OF EMPLOYEE:

EMPLOYEE I.D. #:

POSITION:

SCHOOL/SITE:

This is to verify that the above named employee who has been out of work on

_____ is hereby released to return to work effective
(Leave Type)

_____ according to the physician's statement submitted
(Date)

to the Personnel Office.

Personnel Director or Designee

Date

Employee Signature

Date

Copies to: Personnel, Accounting, Payroll, Employee, Work Site