HUMAN RESOURCE SERVICES
1515 Hughes Way, Long Beach, CA 90810
(562) 997-8204

REQUEST FOR ABSENCE DUE TO MATERNITY
(Pregnancy-Related Disability Leave)

Instructions: All employees requesting absence due to maternity/pregnancy-related disability must submit this completed form (Sections I, II and III) to their payroll clerk/secretary.

I. EMPLOYEE

Last Name _____ First Name _____ MI _____

School/Site _____ Track _____ Job Title _____ Grade/Subject Taught _____

Home Address _____ City _____ Zip Code _____ Phone No. _____

II. ATTENDING PHYSICIAN'S STATEMENT – Certification for Paid Sick Leave

Note to Physician: This form is to verify when the employee will first be unable to work due to a pregnancy-related disability.

It is my opinion that this patient is not able to continue working beginning on:

_____/_____/_____. The estimated date of delivery is: _____/_____/_____.
(month) (day) (year) (month) (day) (year)

Signature of Physician _____ Name of Physician (please print or type) _____ Date _____

Address (Number and Street) _____ City _____ State/Zip Code _____ Phone No. _____

III. EMPLOYEE'S STATEMENT

This form has been signed by my physician. I have read the information regarding *Maternity Leave of Absence* and *Notice of Rights and Obligations*. I understand the period of time it is necessary for me to be absent from my regular duties due to pregnancy-related disability will be charged to my sick leave/vacation/statutory leave balance. I further understand that if I exhaust my accumulated leave balance in the course of this leave, the remaining time will be in leave-without-pay status.

Signature of Employee _____ Date _____