DATE OF LETTER

Director of Human Resources
Edison Board of Education
312 Pierson Ave
Edison, New Jersey 08837

Dear Director of Human Resources:

1. EVERYONE USE THIS PARAGRAPH

Pursuant to the Collective Bargaining Agreement, I would like to request a Medical/Maternity Disability Leave from DATE 1 through DATE 2. My expected date of delivery is DATE 3, as confirmed in the attached statement from my physician.

2. EITHER USE THIS PARAGRAPH IF ALL OF THE LEAVE IS PAID

I wish to apply enter number of A days days of my accumulated sick leave days from DATE 1 through DATE 2. Should school be closed due to inclement weather or any other reason during this time, I request that these day(s) be applied accordingly on to my Maternity Disability Leave.

3. OR USE THIS PARAGRAPH IF ONLY PART OF THE LEAVE IS PAID

I wish to apply enter number of A days days of my accumulated sick leave days from DATE 4 through DATE 5. Should school be closed due to inclement weather or any other reason during this time, I request that these day(s) be applied accordingly on to my Maternity Disability Leave. I am requesting an unpaid family leave for the balance of my Maternity Disability period: from DATE 6 through DATE 7.

THEN

(see next page)

4. USE THIS PARAGRAPH IF ALSO REQUESTING FAMILY LEAVE (UNPAID)

Following the expiration of my Maternity Disability Leave, I wish to apply for a Family Leave under the NJFLI from DATE 8 through DATE 9 during which time I will receive a monetary benefit from the state. I understand the period in which I receive benefits under the NJFLI is considered an unpaid leave by the district. Following the expiration of my Family Leave under the NJFLI, I am requesting an additional unpaid family leave from DATE 10 through DATE 11.

5. USE THE APPROPRIATE CLOSING FOR TYPE OF BIRTH:

It is my understanding that all health benefits will be continued for eighteen (18) weeks after my date of delivery (six weeks maternity disability leave and twelve weeks Family Leave).

OR

Since a Caesarean section is anticipated for the birth, it is my understanding that all health benefits will be continued for twenty (20) weeks after my date of delivery (eight weeks' maternity disability leave and twelve weeks Family Leave).

AND IF APPROPRIATE

Following my Family Leave, I would like to request a Child Care Leave from DATE 12 through DATE 13. I understand that this is an unpaid leave and that I will no longer be covered by insurance unless I purchase benefits through COBRA.

6. FINALLY, FINISH UP WITH:

Thank you for your time and cooperation in this matter.

Sincerely yours,

Sign your name
Type your name and building

pc: << ADD YOUR PRINCIPAL'S NAME >>, Principal
ETEA