Monongalia
COUNTY SCHOOLS

MATERNITY LEAVE REQUEST FORM

EMPLOYEE INFORMATION

Last Name _____ First Name _____

Employee ID# _____ E-mail Address _____

Home Address _____

City _____ State _____ Zip Code _____

Phone number (___) _____

DEPARTMENT INFORMATION

School Name _____ Position _____

Expected Due Date _____

Approximate Dates of Maternity Leave:

Beginning _____ Ending** _____ ⬭ PAID ⬭ UNPAID

*__Please include a script from your Doctor stating your due date__.
**If there is a change in your ending/return date, please contact the Mon.County HR office.
304-291-9210 ext.1501 or 1532

SIGNATURES

Employee _____ Date _____

Monongalia HR Dept. _____ Date _____

FOR OFFICE USE ONLY

Date received by HR: ☐

Board Approval Date: ☐