LAURENS COUNTY BOARD OF EDUCATION
467 FIRETOWER ROAD
DUBLIN, GEORGIA 31021
478-272-4767

MATERNITY LEAVE REQUEST FORM
(To be completed at least 60 days prior to requested leave)

Employee Name: _____ Date: _____/_____/_____

School: _____Grade: _____

EXPLANATION OF FORM:

This form is furnished in accordance with the policy of the Laurens County Board of Education. It must be completed by the physician and employee before leave will be granted.

To be completed by Physician

According to the progress of my patient, it is my belief that she will need to leave work on _____/_____/_____ as her expectant date is _____/_____/_____. Said patient should be able to return to work on _____/_____/_____ if there are no complications.

Work limitations or recommendations: _____

_____

The school authorities will be notified of any change in the patient's condition which might affect her ability to perform her job duties.

_____/_____/_____ _____
Date Physician's Signature

PRINTED OR TYPED NAME OF PHYSICIAN:

Employer's Signatures

_____ _____
Principal's Signature Superintendent's Signature

To be completed by Employee

I understand that I will only be allowed to use my accumulated sick leave for the amount of leave that my doctor specifies on the Physician's Report Form that will be filled out at the time of my delivery and in accordance with the leave policy. I further understand that any time that exceeds this will be non-paid leave. I also understand that if I wish to take an extended non-paid leave beyond the return to work date that I will also need to fill out a third form which is the Family Medical Leave Act Form (which is also unpaid leave).

_____/_____/_____ _____
Date Employee's Signature

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MATERNITY LEAVE – PHYSICIAN'S REPORT
(TO BE COMPLETED AT DELIVERY)

INSTRUCTIONS:

1. **Physician completes and signs (no stamps) form and returns to employee**
2. **Employee sends completed and signed form to Belinda Stanley at Central Office**
3. **Belinda Stanley will copy for leave file and forward to payroll to Melissa Stephens**

Employee Name: _____ Date: _____/_____/_____

Date of Delivery: _____/_____/_____ Normal _____ C-Section _____

Date employee will be able to return to work: _____/_____/_____

If number of days of leave exceeds 6 weeks for normal delivery or 8 weeks for C-Section, please specify patient's complication: _____

_____

_____

_____

_____/_____/_____ _____
DATE PHYSICIAN'S SIGNATURE (NO STAMP)

_____
02012016 PRINTED OR TYPED NAME OF PHYSICIAN