PASADENA UNIFIED SCHOOL DISTRICT

Certificated ☐

MATERNITY LEAVE REQUEST

Classified ☐

Submit completed form to Personnel Services 30 (thirty) calendar days prior to first day of leave.

Section I - *To be completed by employee:*

NAME:_____ LAST 4 DIGITS OF SOCIAL OR EID:_____

JOB TITLE:_____ WORK SITE:_____

MAILING ADDRESS:_____
Number & Street City State Zip Code

TELEPHONE NUMBER:_____ MESSAGE TELEPHONE:_____

_____ _____
Signature of Employee Date

Section II – *To be completed by attending physician* *(PLEASE COMPLETE ALL INFORMATION REQUESTED):*

A. Date which the above-named patient can no longer assume duties and responsibilities of the position which the patient holds with the Pasadena Unified School District.

_____
Date

B. Expected date of delivery:_____

C. Expected date which the above-named patient may again assume normal duties and responsibilities of the position the patient holds with the Pasadena Unified School District.

_____
Date

If the total Maternity leave **(A through C)** is more than ten weeks or less than two weeks, please specify medical reason(s) for unusual duration of leave.

I hereby certify the above:

_____ _____
Signature of attending physician **Name of physician**

Date: _____ _____
California License Number

SECTION FOR PHYSICAN'S ADDRESS STAMP:

Section III – *To be completed by Immediate Administrator*

_____ _____ Date _____
Signature of Immediate Administrator Name of Immediate Administrator

_____ _____ Date _____
Signature of the Human Resources Administrator Name of the Human Resources Administrator

Distribution: Human Resources Immediate Administrator Employee Payroll Benefits