Visalia UNIFIED SCHOOL DISTRICT

REQUEST FOR MATERNITY LEAVE
(PREGNANCY DISABILITY LEAVE)

Employee Name: _____ **Employee ID #:** _____ **HRS/Day:** _____

Work Site/Department: _____ **Position:** _____ **Phone #:** _____

☐ ***CERTIFICATED (VUTA)** ☐ **CERTIFICATED MANAGEMENT** ☐ **CLASSIFIED (CSEA)** ☐ **CLASSIFIED MANAGEMENT)**

***FOR CERTIFICATED, CHECK BOX IF APPLICABLE:**

☐ **I am in the induction program.** ☐ **I am in a dual enrollment position with COS.** ☐ **I currently receive a prep buyout.**

EMPLOYEE ACKNOWLEGEMENT:

***Medical Certification* is required** in order to be eligible for Maternity Leave (PDL). Acceptable medical certification includes completion of the Physician's Statement below or a note from the treating physician that includes the estimated due date and the beginning date the employee will be unable to work due to a pregnancy related disability.

Please check the type of medical certification included with my request: ☐ Physician's Statement (below) ☐ Doctor's note (attached)

I understand that my accumulated sick leave will be used to keep me in a fully paid status during my leave. If/when my sick leave is exhausted, I understand I will be subject to a payroll adjustment. Salary advancement for Management and Certificated employees may be impacted if the employee is not in a fully paid status for 75% of the year or more.

I understand that if I am eligible for FMLA/CFRA, any qualifying leave will be designated to run concurrently with FMLA/CFRA.

Employee Signature: _____ Date: _____

PHYSICIAN'S STATEMENT *(This section is to be completed by your health care provider.)*

Note to Physician: *This form is to verify when the employee will be unable to work due to a pregnancy related disability. Completed form can be returned by the employee to the District Office or faxed to VUSD at (559) 735-8099.*

The patient named above is under my care. It is my opinion that they will not be able to continue working due to a pregnancy related disability beginning on _____ .

The patient's estimated due date is _____ .

_____ _____

Signature of Physician Date

_____ _____

Name of Physician (print or type) Phone Number

FOR HRD USE ONLY

☐ **Approved** ☐ **Denied** Eligible for FMLA/CFRA ☐ Yes ☐ No

Comments:

_____

_____

_____

Approved/Denied By: _____ Date: _____

Return Form to: Human Resources-Employee Benefits
5000 W Cypress Ave, Visalia CA 93277