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| --- | --- |
| **FULL NAME:** |  |
| **DATE:** |  |
| **POSITION/GRADE:** |  |
| **LOCATION:** |  |
| **MAILING ADDRESS:** |  |
| **PHONE #:** |  |
| **EMAIL:** |  |

**MATERNITY LEAVE REQUEST FORM**

**Please complete the following chart when requesting your leave:**

|  |  |
| --- | --- |
| **APPROXIMATE DATE OF BIRTH** |  |

|  |  |  |  |
| --- | --- | --- | --- |
|  | **START DATE** | **END DATE** | **TOTAL DAYS/****WEEKS USED** |
| **SICK TIME PRIOR TO BIRTH** sick time if available(must have Dr.’s note clearing to work if it’s less than 4 weeks prior to anticipated birthdate.)  |  |  |  |
| **30 CALENDAR DAYS AFTER BIRTH**sick time if available |  |  |  |
| **FAMILY MEDICAL LEAVE ACT** FMLA - up to 12 weeks in 12 month periodNo pay with benefits |  |  |  |
| **NJ FAMILY LEAVE ACT**NJFLA - up to 12 weeks in 24 month periodNo pay with benefits |   |  |  |
| **CONTRACTUAL CHILD CARE LEAVE**Not to exceed 24 months after the conclusion of the school year in which the leave is initially grantedLeave of absence without pay or benefits |  |  |  |

|  |  |
| --- | --- |
| **ANTICIPATED RETURN DATE** |  |

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Employee’s Signature Supervisor’s Signature

**Attach medical documentation indicating the approximate date of birth**.

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| 90 Day Notice Given |  | To be completed by Human ResourcesDepartment | Current Health Benefits(S,P/C,ES,F) |  |
| Email-Payroll, HR,School, |  | New Health Benefits |  |
| Date Added to LOA List |  | Health Benefits Contribution |  |
| Board Agenda For Approval |  | Termination of Benefits if Applicable |  |
| Placed on Agenda for Approval |  | Notification of Return |  |