3-WEEK MATERNITY LEAVE FORM

Name:_____ Employee ID:_____

Worksite: ☐ Certificated ☐ Classified Job Title:

For more information regarding this benefit, please refer to the 3-Week Maternity Leave Fact sheet.

DIRECTIONS: Select one of the options below and submit all copies of the completed form to your immediate supervisor within (30) thirty days of delivery.

TO BE COMPLETED BY EMPLOYEE (I certify under penalty of perjury that the foregoing, including all attachments, is true and correct.)

Maternity Leave Time:

Date of Birth: (please attach birth certificate)

☐ Please apply my three (3) weeks of paid maternity leave during the first three (3) weeks of post-partum.

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