

## **3-WEEK MATERNITY LEAVE FORM**

Name:		Employee ID:		
Worksite:	Certificated	Classified	Job Title:	
				For more
information regarding this benefit, plea	ase refer to the 3-Week Ma	aternity Leave	Fact sheet.	
<b>DIRECTIONS</b> : Select one of the option supervisor within (30) thirty days of de		pies of the co	mpleted form to	your immediate
TO BE COMPLETED BY EMPLOYEE (I co	ertify under penalty of perjury t	that the foregoin	g, including all atta	achments, is true and correct.)
Maternity Leave Time:				
Date of Birth:	(please attach	birth certifica	te)	
Please apply my three (3) weeks of	of paid maternity leave dur	ing the first th	ree (3) weeks of	post-partum.