

## Pregnancy Disability Leave Request Form

Employee Name: \_\_\_\_\_ Preferred Phone: \_\_\_\_\_  
Last Name First Name

SSN#: \_\_\_\_\_ Regular work hours per week: \_\_\_ 40 \_\_\_ 31-34 \_\_\_ 20-30 \_\_\_ Other

Days per week scheduled to work: \_\_\_ M \_\_\_ T \_\_\_ W \_\_\_ TH \_\_\_ FRI \_\_\_ SAT \_\_\_ SUN

**In order to request a medical leave of absence, thoroughly complete each section below and follow the How to Apply for a Leave of Absence. This form must be returned to the Office Manager, 30 days prior to your first day of absence, or within 2 days of absence due to unforeseen circumstances.**

### **PREGNANCY DISABILITY LEAVE**

The Pregnancy Disability Leave of Absence policy allows an employee to be away from work, in full workweek increments, on a reduced work schedule, or intermittently. This leave will run concurrent with any applicable federal and/or state leave laws.

Employees may request to take a pregnancy disability leave of absence for any periods of actual disability caused by pregnancy, childbirth or related medical condition, including time off needed for prenatal care, severe morning sickness, doctor-ordered bed rest, and recovery from childbirth. Medical certification from the employee's health care provider will be required. A pregnancy disability leave of absence may be approved for absences up to 12 weeks with medical certification.

### **HOW TO APPLY FOR A LEAVE OF ABSENCE**

1. Read the Pregnancy Disability Leave policy located in the Employee Handbook;
2. Complete this form in its entirety;
3. Obtain the Office Manager's signature

Please note that you have not been approved for a leave of absence until you have received approval from the Office Manager. Unauthorized absences may result in disciplinary actions, up to and including termination of employment.

### **ANSWER ALL QUESTIONS BELOW**

A. \_\_\_ Yes \_\_\_ No

Are you requesting leave due to your own disability caused by pregnancy, childbirth or related medical condition, including time off needed for prenatal care, severe morning sickness, doctor-ordered bed rest, and recovery from childbirth? If you answer "no" then you are not eligible for a Pregnancy Leave. Do not complete this form.

B. \_\_\_ Yes \_\_\_ No

Are you requesting intermittent leave or a reduced leave schedule due to medical necessity? If "yes" provide the Details of your proposed new work schedule. (i.e. M-F 8-12 for three weeks): \_\_\_\_\_

C. \_\_\_ Yes \_\_\_ No

Are you requesting to utilize unused available Sick Leave? If "yes" how many hours? \_\_\_\_\_. Sick Leave will then be paid in accordance with the Sick Leave Policy.

### **DATES OF PREGNANCY LEAVE REQUESTED**

I request leave to begin on (1<sup>st</sup> work day of absence) \_\_\_\_\_

I will return to work on (1<sup>st</sup> returning work day) \_\_\_\_\_

**EMPLOYEE STATEMENT**

I certify that I have read and understand the pregnancy disability leave of absence policy. I understand the instructions on this form and will comply with the leave of absence policy.

Employee Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Print Name: \_\_\_\_\_

**OFFICE MANAGER**

Manager Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Print Name: \_\_\_\_\_