

REQUEST FOR MATERNITY LEAVE

*This request with the Certificate of Disability Form should be mailed to the Certified Personnel Department 60 days before the expected birth of your child.*

SOCIAL SECURITY NUMBER \_\_\_\_\_ DATE \_\_\_\_\_

NAME \_\_\_\_\_

SCHOOL \_\_\_\_\_ IF TEACHER, WHAT GRADE AND/OR SUBJECT(S) \_\_\_\_\_

THE EXPECTED DATE OF BIRTH OF MY CHILD IS \_\_\_\_\_

I AM REQUESTING MATERNITY LEAVE TO BEGIN AT THE CLOSE OF THE SCHOOL DAY ON

\_\_\_\_\_  
Last day to Work

I EXPECT TO RETURN TO WORK ON \_\_\_\_\_

DO YOU WANT TO USE SICK LEAVE DAYS? \_\_\_\_\_ IF YES, HOW MANY DAYS DO YOU WANT TO USE? \_\_\_\_\_. \*\*IF YOU EXHAUST YOUR CURRENT AND ACCUMULATED SICK LEAVE DURING YOUR PERIOD OF DISABILITY, DO YOU WANT TO GO ON EXTENDED SICK LEAVE? \_\_\_\_\_

**\*\*Please be reminded that you may use any or all of your sick leave during the time of disability while on maternity leave provided your physician certifies, in writing, the date to commence and terminate your sick leave. In order to be paid during your entire period of disability, you must use all of your current and accumulated sick leave days to cover you during this time. If you exhaust all of your current and accumulated sick leave days and want to go on extended sick leave during your period of disability, you will continue to get sixty-five percent of your salary. You are eligible for a maximum of 90 days of extended sick leave during a six-year period.**

**Note the Following Regarding Maternity Leave - (1) A Certificate of Disability Form must be completed by your physician and returned to the Certified Personnel Department before you can be paid for sick leave. (2) The sabbatical leave law mandates completion of the Certificate of Disability to determined non-interruption of consecutive service for sabbatical leave purposes. The certificate must be returned regardless of your decision to utilize sick leave days or not. (3) A statement from your physician authorizing your return to work must be submitted to the Certified Personnel Department in order for you to be reinstated to active employment and to receive your paycheck(s). (4) Completion of this maternity leave form is not mandatory. You may elect to use normal sick leave as outlined in Board Policy G CBD.**

I understand the above requirements and agree to provide the documents indicated.

\_\_\_\_\_  
Employee's Signature

\_\_\_\_\_  
Home Telephone Number

\_\_\_\_\_  
Address

\_\_\_\_\_  
City/State/Zip Code

\_\_\_\_\_  
Principal/Supervisor's Signature

**DO NOT DETACH**

.....  
**THIS PORTION TO BE COMPLETED BY YOUR PHYSICIAN**

This is to certify that the above named patient is pregnant. She will be confined by childbirth and unable to work from

\_\_\_\_\_ to \_\_\_\_\_. The expected date of the birth of her child is \_\_\_\_\_.

\_\_\_\_\_  
Physician's Signature

\_\_\_\_\_  
Address

\_\_\_\_\_  
Please type or print name

\_\_\_\_\_  
Telephone number

CADDO PARISH SCHOOL BORAD  
CERTIFIED PERSONNEL DEPARTMENT  
1961 MIDWAY STREET (P. O. BOX 32000)  
SHREVEPORT, LA 71108

CERTIFICATE OF DISABILITY

CURRENT DATE \_\_\_\_\_

THIS IS TO CERTIFY THAT \_\_\_\_\_  
EMPLOYEE'S NAME

SOCIAL SECURITY NUMBER \_\_\_\_\_

SCHOOL/DEPARTMENT \_\_\_\_\_

WILL BE/WAS CONFINED BY CHILDBIRTH FROM \*\* \_\_\_\_\_  
MONTH/DAY/YEAR

TO \_\_\_\_\_ \*\*If the period of disability requested is more than 6-8 weeks,  
MONTH/DAY/YEAR an examination by the board-selected physician may also  
be required prior to approval.

IT WILL BE/WAS MEDICALLY UNFEASIBLE FOR HER TO PERFORM NORMAL DUITES DURING  
THIS PERIOD.

\_\_\_\_\_  
Physician's Signature

\_\_\_\_\_  
Type or Print Name

\_\_\_\_\_  
Address

\_\_\_\_\_  
City/State/Zip Code

\_\_\_\_\_  
Telephone Number

PLEASE RETURN THIS FORM TO THE CERTIFIED PERSONNEL DEPARTMENT