EAST RUTHERFORD PUBLIC SCHOOLS

Business Office

250 Grove Street

East Rutherford, NJ 07073

REQUEST FOR MATERNITY LEAVE OF ABSENCE

Print Name:_____ Date of Request:_____

Anticipated Date of Delivery:_____ Last Day of Work:_____
(Attach Doctor's Note)

- Disability Period Prior to Birth From:_____ To:_____
  (Maximum of four (4) calendar weeks prior to birth unless a doctor's note states differently, in order to be paid.)

  Number of Sick Days that will be used prior to birth:_____
  (Sick Days must be used for disability leave, in order to be paid.)

  Disability Period after Birth From:_____ To:_____
  (Maximum of four (4) calendar weeks for natural birth and six (6) calendar weeks for C-Section Unless a doctor's note states differently, in order to be paid.)

  Number of Sick Days that will be used for Disability Leave:_____
  (Sick Days must be used for Disability Leave)

  Total Number of Sick Days to be used for Disability Leave:_____

- Federal FMLA and NJFLA Period From:_____ To:_____
  (Up to 12 calendar weeks. Begins at the conclusion of Disability Period. Shall be with Health Benefits)

  Total number of FMLA Days to be used:_____

- Maternity or Paternity Leave From:_____ To:_____
  (Unpaid, No Paid Health Benefits)

I will return to my position on:_____

REMINDER: MUST BE ACTIVE EMPLOYEE FOR NINETY (90) DAYS TO BE ELIGIBLE FOR SALARY GUIDE INCREMENT FOR THE FOLLOWING SCHOOL YEAR AND MUST BE AN EMPLOYEE FOR 1 YEAR TO RECEIVE FMLA

Employee Signature:_____

For ERBOE: Letter from Employee received on:_____

Approved by BOE Resolution dated: _____

Signed:_____ Date returned to Employee:_____

Encl copy of BOE Resolution