HUMAN RESOURCE SERVICES
1515 Hughes Way, Long Beach, CA 90810
(562) 997-8651

RETURN TO WORK FROM PREGNANCY-RELATED DISABILITY LEAVE
(Maternity Leave)

Instructions: All employees returning from a pregnancy-related disability/maternity leave must submit this completed form (Sections I, II and III) to their site payroll clerk/secretary.

I. EMPLOYEE

Last Name	First Name	MI

School/Site	Track	Job Title	Grade/Subject Taught

Home Address	City	Zip Code	Phone No.

Inclusive Dates of Absence: From_____ To_____

II. ATTENDING PHYSICIAN'S STATEMENT – Certification for Paid Sick Leave

Note to Physician: This form is to verify when the employee will first be able to return to work following a pregnancy-related disability leave. Paid leave normally ends six weeks post partum (eight weeks for c-section) unless there is a verified medical complication.

Date of Delivery: _____

This individual is able to return to full duty with/without restrictions on _____/_____/_____.

If applicable, please note restrictions including duration: _____

_____

_____
Name of Physician Signature Date

_____(___)_____
Address City Phone

III. EMPLOYEE'S STATEMENT

- ❒ I intend to return to work on date as indicated in physician's statement above.
- ❒ I intend to request CFRA Child Bonding Leave.
  (Please complete and submit *Request for CFRA Child Bonding Leave* form.)
- ❒ I do not plan to return to work at this time. I intend to request unpaid Child Care Leave.
  (Please complete and submit *Request for Leave of Absence (Without Pay)* form)

Signature _____ Date: _____