Education...Empowers...Excellence

Dr. Frank Devono, Superintendent

MATERNITY LEAVE REQUEST FORM

EMPLOYEE INFORMATION

Last Name ______________________________ First Name _______________________________

Employee ID# ___________________________ E-mail Address ____________________________

Home Address ____

City _______________________________ State _________ Zip Code _____________________

Phone number (____) ___________________________

DEPARTMENT INFORMATION

School Name _____________________________ Position ________________________________

Expected Due Date _________________________________

Approximate Dates of Maternity Leave:

Beginning __________________ Ending** ____________________ ⬭ PAID ⬭ UNPAID

***Please include a script from your Doctor stating your due date**.
**If there is a change in your ending/return date, please contact the Mon.County HR office. 304-291-9210 ext.1501 or 1532

SIGNATURES

Employee ____________________________________ Date _______________________________

Monongalia HR Dept. _____________________________ Date ____________________________

FOR OFFICE USE ONLY

Date received by HR: [ ]

Board Approval Date: [ ]