



HUMAN RESOURCE SERVICES
1515 Hughes Way, Long Beach, CA 90810
(562) 997-8204

**RETURN TO WORK FROM MATERNITY LEAVE
(Pregnancy-Related Disability Leave)**

Instructions: All employees returning from a maternity leave/pregnancy-related disability 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 do not plan to return to work at this time. I intend to request family leave/child care.
(Please complete and submit *Request for Leave of Absence (Without Pay)* form)

Signature _____ Date: _____