PGCEA 10 DAY PAID MATERNITY/PATERNITY LEAVE REQUEST

Please return completed forms to Absence Management
14201 School Lane, Room 132 Upper Marlboro, MD 20772
Phone: 301-952-6200. Fax: 301-952-6312. Email: absence.mgmt@pgcps.org

SECTIONI I: TO BE COMPLETED BY THE EMPLOYEE: Please complete Section I before giving this form to your health care provider. Submit this form within six weeks of birth and a*ttach* ***proof of birth (Required).***

EMPLOYEE'S INFORMATION:

Employee's Name: _____ EIN: _____
First Middle Last

Work Organization: _____ Job Title: _____

Employee's Signature: _____Home/Cell Phone #:_____Date: _____

*** **Please remember to add your newborn to your benefits through Oracle Self-Service within 35 days of birth. If you need assistance contact Benefits Services at 301-952-6600.** ***

SECTION II: TO BE COMPLETED BY THE HEALTH CARE PROVIDER:

Date of Delivery: _____

Comment: _____

_____

_____

_____

I declare under penalty of perjury that I have examined all the information on this form, and on any accompanying statements or forms, and it is true and correct to the best of my knowledge. I understand that anyone who knowingly gives a false or misleading statement about a material fact in this information, or causes someone else to do so, commits a crime and may be sent to prison, or may face other penalties, or both.

Health Care Provider's Name: _____Provider's ID # _____ **(Required)**

Business Address: _____

Practice specialty: _____

Telephone: (_____) _____Fax: (_____) _____

Signature of Health Care Provider: _____ Date: _____