

Maternity and Parental Medical Leave Form

Please print and complete this form. Submit the finalized copy to the Human Resources Department along with any required medical certifications.

1. Employee Information

Full Name:

Employee ID:

Department / Division:

Job Title:

Contact Phone Number:

Email Address:

2. Leave Request Details

Type of Leave Requested (Specify Maternity, Parental, or Medical Extension):

Expected Leave Start Date (YYYY-MM-DD):

Expected Date of Return to Work (YYYY-MM-DD):

3. Medical Information (To be completed by Healthcare Provider if applicable)

Healthcare Practitioner Name:

Medical Specialty:

Expected Date of Birth / Confinement (YYYY-MM-DD):

Relevant Medical Notes or Accommodation Requirements:

Healthcare Practitioner Signature (Print Name & Sign):

Date Signed (YYYY-MM-DD):

4. Acknowledgment and Signatures

I certify that the information provided on this form is accurate and complete to the best of my knowledge.

Employee Signature:

Date Signed (YYYY-MM-DD):

5. Employer Approval (For HR / Management Use Only)

Authorized Manager / HR Name:

Approval Status (Approved / Pending / Denied):

Manager / HR Signature:

Date Signed (YYYY-MM-DD):