Staff Maternity Leave

(Physician's Statement Regarding Continued Disability
Related to Pregnancy, Childbirth or Miscarriage)

NOTE: This form is only to be used when a request is being made for an extension of the 30 days normally allowed following pregnancy, childbirth or miscarriage. Trinidad School District policy requires that if the disability continues and the staff member is requesting sick leave, this form must be completed on a weekly basis.

Date:_____

Patient's name_____

This is to certify that the above patient is still temporarily disabled as a result of (circle one) pregnancy/childbirth/miscarriage and is unable to perform her normal work duties. It is my professional opinion that this disability will continue commencing _____and ending on

_____(not to exceed seven calendar days).

Please include a brief statement as to why this person's disability has continued beyond the normally allowed 30 days, which was caused or contributed to by pregnancy, childbirth or miscarriage.

_____

_____

_____

_____

Physician's name _____

Physician's signature _____

Date _____

Physician's address _____

Physician's phone number _____

Patient's signature _____

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