OXNARD SCHOOL DISTRICT

1051 South "A" Street ● Oxnard, California 93030 ● 805/385-1501

MATERNITY LEAVE FORM

TO BE COMPLETED BY PHYSICIAN:

Name: _____

is a patient under my care for pregnancy.

She may work until (last day able to render service) _____

Estimated date of delivery _____

Date patient will be able to resume normal duties (may be stated as "___ weeks following birth of child")
_____

Doctor's Signature: _____

(Please attach doctor's business card)

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TO BE COMPLETED BY EMPLOYEE:

Based upon the foregoing information, I am applying for sick leave during the period of disability stated. This disability prevents me from rendering service to the District

NOT LESS THAN SEVEN DAYS PRIOR TO RETURN TO DUTY, I SHALL SUBMIT A WRITTEN STATEMENT FROM MY PHYSICIAN INDICATING MY FITNESS TO PERFORM NORMAL DUTIES

Signature: _____

School: _____

Date: _____