MATERNITY/PATERNITY LEAVE BANK APPLICATION

INSTRUCTIONS & IMPORTANT STEPS FOR APPLICANTS:

- ☐ **Must submit an electronic FMLA application directly to DCPS for approval.**
- ☐ **Must complete a WTU Maternity/Paternity Leave Bank application and attach an electronic copy of the approved FMLA letter from DCPS.**
- ☐ **Must be enrolled in the Maternity/Paternity Leave Bank for at least three (3) months prior to your application being submitted. (Must have selected the Maternity/Paternity Leave Bank during the WTU Dental and Vision Open Enrollment in August of every school year via the online WTU Bswift benefits website).**
- ☐ **Must have donated one day of your annual 12 days of Maternity/Paternity leave granted each year into the Maternity/Paternity Leave Bank via DCPS payroll deduction.**
- ☐ **Must request to take Maternity/Paternity Leave during the school year and not during holiday and/or summer breaks.**
- ☐ **Must submit a doctor's notice on letterhead specifying the time needed for recovery.**
- ☐ **Must have a signed approval by your physician/doctor on the WTU application and FMLA form.**
- ☐ **The dates requested cannot exceed the approved dates granted by DCPS.**
- ☐ **Must fax completed leave application to: 202-379-3404**
  OR email to: info@wtulocal6.net

OR mail to: **WTU Membership Services Department**
1239 Pennsylvania Avenue, S.E.
Washington, D.C. 20003

PLEASE ALLOW FOR THE NORMAL PROCESSING TIME OF 15 BUSINESS DAYS.

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Part I – THIS SECTION TO BE COMPLETED BY APPLICANT

First Name: _______________________________ MI: _____ Last Name: ______________________________

Address: _________________________________ City: _____________________ State: _______ Zip: ___________

Phone: ___________________________________SSN: ______________________ DCPS ID: ___________________

Email Address: ____

Attending Physician/Doctor and phone: ____

School: ____ Years of service at DCPS: ________

I request a grant of __________ days from the Maternity/Paternity Leave Bank. (You MUST request no less than 5 days)

Leave Start Date: ____________________ Leave End Date: _____________________

Employee Signature: _______________________________________ Date: _________________

Part II – THIS SECTION TO BE COMPLETED BY PHYSICIAN/ADOPTION AGENCY

Duration of Time Needed for Recovery: ______________________________

Physician/Doctor Signature: _______________________________________ Date: __________________

Physician Phone Number: ____

Part III – THIS SECTION TO BE COMPLETED BY LEAVE BANK ADMINISTRATOR ONLY

Current Request: ______**APPROVED** ______**DISAPPROVED**

Leave Start Date: _________________________ Leave End Date: _________________________

Disapproved Reason: ____

Authorized Signature: ____ Date: ________________