



MATERNITY/PATERNITY LEAVE BANK APPLICATION

INSTRUCTIONS & IMPORTANT STEPS FOR ALL APPLICANTS:

- Must submit the FMLA form directly to DCPS for Approval.
- Must complete a WTU Maternity/Paternity Leave Bank application and attach an approved FMLA form from DCPS.
- Must be enrolled in the Maternity/Paternity Leave Bank for at least 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 sick leave granted each year into the Maternity/Paternity Leave Bank via DCPS payroll deduction.
- Must request to take Maternity Leave during the school year and not during holidays and/or summer breaks.
- Must have a signed approval by your physician/doctor on the WTU application and FMLA form.
- Must request no less than 5 days and no more than 30 days of leave.
- Must fax completed leave applications to: **202-517-0673** OR email to:

info@wtulocal6.net OR mail to:

**WTU Membership Services Department
1239 Pennsylvania Ave SE
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 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 Address and Phone Number: _____

Part III – THIS SECTION TO BE COMPLETED BY WTU MEMBERSHIP DIRECTOR ONLY

Current Request: _____ APPROVED _____ DISAPPROVED

Leave Start Date: _____ Leave End Date: _____

Disapproved Reason: _____

Authorized Signature: _____ Date: _____
