Maternity Leave Catastrophic Leave Application Form

Section 1: Employee Details (to be completed by employee)

Name (Last, First, Middle Initial)	**UCA ID NUMBER:** **B**	**Position Title:**
Department Name and Organization number:	**Work Phone No.**	**Home Phone No.**

CERTIFICATION: I certify that I am pregnant described on the attached Physician's certificate since the date indicated below. I further certify that I agree to the Maternity policy and that I comply with the requirements of the University.

Section 2: Pregnancy/Adoption Details

Where you are not yet able to provide details, insert TBA and provide the details when you are able.

The expected day/ week of my childbirth (EWC)/adoption is:

Please attach proof of pregnancy/adoption with this form or submit when you have it.

Section 3: Maternity Leave Details

The date of paid maternity (CAT) begins on the day of your baby's birth.

Remember:

- **To advise us of this date as soon as reasonably practical.**

Upon meeting eligibility requirements, the day that you give birth up to four weeks will be paid leave.

- **If your maternity leave starts before the planned date, for example due to early childbirth, you need to notify us as soon as reasonably practical.**

- **Should you give birth early, you need to notify us of the date of childbirth.**

Remember:

- **You must bring a doctor's release form to return to work.**

(TO BE COMPLETED BY PHYSICIAN)

UNIVERSITY OF CENTRAL ARKANSAS
PHYSICIAN'S CERTIFICATION FOR MATERNITY LEAVE

PHYSICIAN NAME _____
(PRINT OR TYPE) Last First Middle

PHYSICIAN ADDRESS _____
Street City/State Zip Code

PATIENT NAME _____

AUTHORIZATION TO RELEASE INFORMATION; I hereby authorize the undersigned physician to release any and all information acquired in the course of my examination or treatment for the purpose of consideration by the Catastrophic Leave committee for my Maternity leave.

_____
(DATE) EMPLOYEE'S SIGNATURE (OR LEGAL REPRESENTATIVE)

_____
(DATE) PATIENT'S SIGNATURE OR LEGAL REPRESENTATIVE (If different than employee)

THE EMPLOYEE IS RESPONSIBLE FOR THE COMPLETION OF THIS FORM AT HIS/HER OWN EXPENSE. ALL INFORMATION LISTED ON THIS FORM WILL BE KEPT CONFIDENTIAL.

(To be completed by the Attending Physician)
THE FOLLOWING QUESTIONS APPLY ONLY TO MATERNITY LEAVE

1. HISTORY

a. Pregnancy due date Mo._____ Day_____

_____
CLINIC NAME SIGNATURE OF ATTENDING PHYSICIAN

_____
ADDRESS DATE

_____
TELEPHONE

RULES AND REGULATIONS OF CATASTROPHIC MATERNITY LEAVE

A. The Catastrophic Leave Committee shall review each request and ascertain that the following rules are adhered to before recommending approval of any request for Maternity Leave.

B. To be eligible to receive Maternity Leave, employees of the University of Central Arkansas shall be in compliance with the following rules:

1. The employee must be a regular, full-time, classified or non-faculty non-classified employee who is receiving compensation on a full-time basis;

2. The employee must have been employed by the state for more than one (1) year.

3. An acceptable medical certificate from a physician supporting the pregnancy must be on file.

4. In the context of this policy and relevant legislation, adoption of a child is also grounds for requesting a maternity leave. Parents may need to utilize time off to meet appointments related to the adoption process or to bond with a recently adopted child. The same guidelines and procedures apply for these cases.

5. The University's maternity leave policy outlines the provisions for women employees who are expecting a child and/or require time to care and bond with their newborn. The University endorses the right of its employees to become parents. We are also aware that pregnancy or caring for an infant or a newly adopted child may cause difficulties for them in relation with their job duties. We are, therefore, prepared to support pregnant employees and allow new mothers enough time to recover from childbirth and care for their child.

(TO BE COMPLETED BY EMPLOYEE)

CATASTROPHIC LEAVE BANK PROGRAM
MATERNITY LEAVE

RELEASE FROM LIABILITY

I have read and understand the rules and regulations of the Catastrophic Leave Bank (CLB) Program and the Maternity Leave Policy requirements.

I understand that I will forfeit the benefits of the Catastrophic Leave Bank by:

1. Resignation or termination of employment with the State of Arkansas.
2. Any fraud or misrepresentation of facts in making application for leave from the Catastrophic Leave Bank.

I understand that alleged abuse of the CLB will be investigated, and, on a finding of wrongdoing, I will repay all of the leave hours drawn from the CLB and will be subject to such other disciplinary action as is determined by my agency director/institution head.

I further understand that the Catastrophic Leave Bank Committee is not an agency, board, or other subdivision of the State of Arkansas. The Committee's decisions are not grievable, arbitrable, or litigable, and its actions are appealable only to the agency director/institution head.

_____

Employee Signature

_____

Date