Protecting Pregnant Workers Fairness Act of 2014 (PPWFA) Form

THIS FORM WILL NOT BE PLACED IN YOUR APPLICATION OR PERSONNEL FILE AND WILL BE MAINTAINED WITHIN THE EEOA OFFICE. THE CONTENTS OF THIS REQUEST WILL BE KEPT IN CONFIDENCE EXCEPT AS NEEDED TO FACILITATE THE REQUEST.

Name: _____ Job Title: _____
GWID: _____ Email Addresses(s): _____
Dept. Name/School: _____ HR Representative: _____
Supervisor's Name & Title: _____ Supervisor's #: _____

Contact Information

Home Address & Phone Number	GW Location Address & Phone Number

Are you eligible for and/or using leave under the Family and Medical Leave Act? Yes No
Are you eligible for and/or using short/long term disability? Yes No

You may attach any medical documentation that may assist us in making a determination in your case. Please be advised in some cases medical documentation may be required. Approved DC PPWFA leave is 6 weeks for a regular delivery or 8 weeks for a C-Section.

Requested time frame for leave? M____D_____Y_____ (Start) M____D____Y_____(End)
_____
_____

Medical Provider(s) Name: _____
Address: _____
Phone Number: _____ Fax Number: _____ Email: _____

I AM REQUESTING LEAVE DUE TO THE BIRTH OF A CHILD. TO ASSIST EEOA IN THIS REQUEST, I AGREE TO PROVIDE ADDITIONAL DOCUMENTATION AND/OR A RELEASE FOR EEOA TO DISCUSS MY ACCOMMODATION REQUEST WITH THE APPROPRIATE MEDICAL PROFESSIONAL.

Employee Signature: _____ ***Date:*** _____

EEOA Receipt Date