Early Learning Coalition of the Nature Coast
Serving Citrus-Dixie-Gilchrist-Levy-Sumter Counties

Maternity Leave

I ________________________________ have been informed of the following in regards to my maternity leave:

1. I must inform the Early Learning Coalition of the Nature Coast of the last day that I go to work before delivery of my baby or within ten (10) days of delivery in the case of unforeseen circumstances.

2. My children who are currently enrolled with the Early Learning Coalition of the Nature Coast may not attend child care while I am on maternity leave *unless* medically necessary as documented by my physician; my eligibility will remain active. (Call your Coalition office for ELCNC-218 Verification of Disability (also available on the Coalition's website @ www.elc-naturecoast.org)

3. I understand that I am allowed a maximum of sixty (60) days child care services, if medically necessary, and documented as outlined above.

4. I must schedule an appointment with the Early Learning Coalition of the Nature Coast to show proof of employment and/or education before my children may return to child care.

5. If my funding for services is BG8 and I complete a waitlist application, the baby will be placed on the waiting list for services. If I am funded through One Stop, DCF or its partnering agencies, I will need to obtain a new referral with the baby's name included.

6. I understand that I am required to submit proper documentation from my doctor to verify the dates of my maternity leave.

I acknowledge my responsibility to contact the Early Learning Coalition of the Nature Coast with the required documentation. I understand that if I do not comply with this process my child care will be terminated. I understand all information on this page. I am signing this document of my own free will to continue services with the Early Learning Coalition of the Nature Coast.

______________________________ ______________
Parent/Caregiver Signature Date

______________________________ ______________
ELC Staff Signature Date

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To Be Completed by Employer:

Employee Name: ______________________________ Last 4 SSN: __________

Company Name: ______________________________ Phone No.: ______________

Last Day of Work Before Maternity Leave: ____________ Date Employee Will Return to Work: ____________

How many hours will the employee work per week? ________

Rate of Pay: $________ per ☐ Hour ☐ Week ☐ Month ☐ Other (please explain) ______________

Name of Person Completing Form: ______________________

Title: ______________________________

Signature: ______________________________ Date: ______________