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 email completed leave application to: benefits@wtulocal6.net
or mail to: WTU Membership Services Department
1239 Pennsylvania Avenue, SE
Washington, D.C. 20003

NORMAL PROCESSING TIME: 15 BUSINESS DAYS.
Maternity/Paternity Leave Bank Application

1 – THIS SECTION TO BE COMPLETED BY APPLICANT

First Name _____________________________   M/ I: ____________  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: ________________________________

Duration of Time Needed for Recovery: _______________________________ Physician Phone Number: _________________________________

Physician/Doctor Signature:____________________________________________ Date: _______________

2 – THIS SECTION TO BE COMPLETED BY PHYSICIAN/ADOPTION AGENCY

3 – THIS SECTION TO BE COMPLETED BY LEAVE BANK ADMINISTRATOR

Current Request: __________________ APPROVED          __________________ DISAPPROVED \\ Leave Start Date: _______________________________ Leave End Date: _____________________________________

Disapproved Reason:________________________________________________________

Authorized Signature ___________________________________________ Date: ________________________________