



New Request

Request for Alteration

PLEASE RETURN THIS FORM TO YOUR DESIGNATED HR PERSONNEL AT LEAST 10 BUSINESS DAYS BEFORE YOUR ANTICIPATED RETURN FROM CHILD BONDING LEAVE.

Name: _____ DSW# or SSN: _____ Class/Title: _____

Address: _____ City: _____ State: _____ Zip: _____

Contact No.: _____ Home Email: _____ Dept.: _____

Supervisor: _____

Employment Status: Permanent Exempt
 Probationary Temporary Provisional

Start Date for Requested Accommodation: ____/____/____

Birthdate of Child: ____/____/____

Requested Number of Breaks Per Day: _____

I wish to use accrued: SP VA CTO FH during my unpaid breaks.

-OR-

First Lactation Break

Requested Start and End Time:

____:____ to ____:____

Second Lactation Break

Requested Start and End Time:

____:____ to ____:____

Third Lactation Break

Requested Start and End Time:

____:____ to ____:____

Fourth Lactation Break

Requested Start and End Time:

____:____ to ____:____

The Department may provide a flexible schedule, allowing you to make up unpaid break time if it is feasible given the operational demands of the Department.

I am requesting a schedule that will allow me to make up unpaid break time and work the full amount of my regularly scheduled hours.

 Employee Signature

 Date

YOU MAY BE CONTACTED BEFORE YOUR RETURN TO WORK TO DISCUSS THE REQUESTED LACTATION ACCOMMODATION AND ASSIST YOU IN TRANSITIONING BACK TO THE WORKPLACE AS A NURSING MOTHER.

PRINT NAME/TITLE	SIGNATURE	DATE	APPROVE	DENY (Attach Reason ¹)
(Employee's Supervisor)				
(Personnel Officer/Designee)				

cc: Leave/Medical File

¹ A request for lactation accommodation must be approved unless the requested break time will seriously disrupt the operations of the Department.
 (Rev. 5/2017)