CITY AND COUNTY OF SAN FRANCISCO
REQUEST FOR LACTATION ACCOMMODATION

Complete and return this form at least 10 business days before your return to work

☐ New Request ☐ Request for Alteration

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

Address: _____ **City:** _____ **State:** ____ **Zip:** _____

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

Supervisor: _____

Employment Status: ☐ Permanent ☐ Probationary ☐ Temporary ☐ Provisional ☐ Exempt

Start Date for Requested Accommodation:
_____/_____/_____

Birthdate of child:____/____/_____

Requested Number of Breaks Per Day:
_____

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_____:_____

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

The Department may provide a flexible schedule allowing you to make up unpaid break time to the extent 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 to work the full amount of my regularly schedule hours.

_____ _____
Employee Signature **Date**

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

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

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

cc: Leave/Medical File

***A request for lactation accommodation must be approved unless the requested break time will seriously disrupt the operations of the Department.**