CERTIFICATION OF PREGNANCY AND EXPECTED DUE DATE

I. To be Completed By Employee:

This statement attests that I or my spouse are receiving pre-natal care services and expected to deliver on or about _____.

Employee Name: (Print) _____

Physician's Name: (Print) _____

Address: _____

City: _____ State: _____ Zip Code: _____

Does your spouse work for the City of Springfield? O Yes O No

If yes, indicate department: _____

Spouse's Name: (Print) _____

This form must be submitted to Human Resources no later than the end of the second trimester (26th week). Failure to submit form timely will result in denial of the four (4) week paid parental leave.

II. To Be Completed By Human Resources:

O Maternity Benefits O Paternity Benefits

O Approved O Denied

HR Representative's Signature: _____ Date: _____

III. To Be Completed By Payroll:

Representative's Signature: _____ Date: _____