Faculty Parental/ Adoption Leave Request Form

Part I – Parental/Adoption Leave Request

I wish to be granted Parental Leave as Primary Caregiver:

☐ for the birth of child(ren)

☐ for adopting child(ren)

Faculty Member's Immediate Supervisor:	
Faculty Member's Immediate Supervisor's Signature:	
Department Chair's Name:	

Faculty Name:	
WFU ID Number:	Department:
Home Address:	
Home Phone:	Campus Phone:
Faculty Signature:	Date:

Part II - Physician's Certification
To: Attending Physician

Under the policy of my employer, Wake Forest University, an eligible faculty member is eligible for a semester of paid parental leave to allow for health recovery and family adjustment associated with pregnancy, termination of the pregnancy, and childbirth. Please furnish the information below:

Name (if different from faculty member employee listed above):	
Expected date of delivery:	
I recommend she not continue work after (date), if applicable:	
Comments (if any):	
Physician's Name:	
Physician's Signature:	Date:
Physician's Practice Name:	
Physician's Address:	

Primary Caregiver Affidavit

I certify that I meet the following requirements under the Paid Parental Leave Policy:

1. I am the natural parent, same sex spousal equivalent, or new adoptive parent (individuals adopting a spouse or partner's natural child(ren) are not eligible). I will provide a certificate of birth or adoption following the event.

2. I will be the primary caregiver during the paid leave during semester _____. (The parent who will be responsible for more than 50% care of child during this time.)

3. My spouse or same sex spousal equivalent will not be receiving a similar benefit though his/her employer.

4. I understand that this leave will count towards my 12 weeks of job-protected Family Medical Leave.

If both parents work for the University and both qualify for this benefit, only one leave will be granted but the allowed time of the parental leave may be divided between two consecutive time periods selected by the parents.

I understand that if it is determined that I am not the primary caregiver to my child during this time that I will no longer be eligible for the benefit and may be required to repay salary received during the paid parental leave.

I acknowledge that if the information I have provided above is accurate, and I understand that any falsification of information may lead to disciplinary action up to and including termination.

_____   _____   _____
Printed Name   Signature   Date