County of Goliad

Paid Parental Leave Benefits Request

Employee Name (Print): _____ Phone: _____

Department: _____Email: _____

Reason PPLB is being requested _____ Birth _____ Adoption _____ Placement for Adoption

	ANTICIPATED	**ACTUAL**
Date of Birth, Adoption, Placement		
Date Use of PPLB Begins		
Date Use of PPLB Concludes		

Requested PPLB Use of PPLB _____ Continuous _____ Intermittent Use*

* Please describe why you are requesting Intermittent PPLB: _____

_____

_____

_____

_____

Employee Certifications (Initial Each Box)

_____ I acknowledge that I have received my copy of the Paid Parental Leave Benefits Policy and that it is my responsibility to read and comply with the policies and procedures in this Policy and any revisions made to it.

_____ I attest that PPLB is being taken because of the birth, adoption, or placement of a child for adoption and that the PLLB will be used in connection with my fulfillment of my parental role to care for and bond with the child.

_____ I understand that employees are not allowed to engage in any employment during the time the employee is taking PPLB.

_____ I will provide signed documentation supporting this request to my department and the County Human Resources Department, within thirty (30) days of the birth, adoption, or placement of a child for adoption.

_____ I acknowledge and understand the consequences of providing a false certification that may be possible disciplinary action and/or termination.

_____ If I am providing an anticipated date or birth, adoption or placement of a child for adoption, I will notify my department head as soon as possible of the actual date, but no later than seven (7) days after the birth, adoption, or placement of a child for adoption.

_____ I understand that employees out on Workers Compensation or Leave of Absence are not eligible for PPLB.

_____ I understand that the PPLB is a supplement for my existing sick and vacation leave at the time of the qualifying event (birth, adoption, or placement of a child for adoption) and will run concurrently with my FMLA leave to the fullest extent possible. I also recognize that my PPLB must be approved by my Department Head and Human Resources.

_____ I understand that while taking PPLB, I am required to follow my department's call-in procedures. I will notify my Department Head and Human Resources when there are changes to the circumstances of my leave and provide an updated medical certification, as required. I understand that my supervisor or Human Resources may contact me during my leave period to verify my status and obtain updates as to my estimated date of return to work.

_____ I certify that the information provided is true and correct and confirm that the PPLB is being taken to bond with my newborn, adopted child or child who is pending an adoption (17 years of age or younger) that is a newly added member of my household. I understand that if I have falsified any information related to my PPLB request or violated any of the PPLB requirements, I may be required to reimburse the County for any of the PPLB that I had received and it may lead to disciplinary action, including termination of my employment.

_____ I understand that PPLB does not my dependent child to my health care benefits.

Employee Signature: _____ Date: _____

Department Head Signature: _____ Date: _____

APPROVE / DENY

Human Resources Representative: _____ Date: _____

APPROVE / DENY