MADERA UNIFIED SCHOOL DISTRICT

Human Resources Department

LACTATION ACCOMMODATION FORM

☐ CERTIFICATED ☐ CLASSIFIED

NAME: _____ SSN #: XXX-XX-_____

JOB TITLE: _____ WORK SITE: _____

START/END TIME: _____ HOURS PER DAY: _____

BREAK TIMES: _____ LUNCH PERIOD: _____

Approximate Lactation Break Duration/Frequency: _____

_____

Employee acknowledgment

I have received a copy of and read the *Fair Labor Standards Act (FLSA)* Guidelines on Break Time for Nursing Mothers, and I will agree to comply with these Guidelines. I understand that I will notify my immediate supervisor and my HR Technician as soon as I do not require a lactation accommodation or if there is a need of a change to my lactation accommodation plan.

_____ _____

Employee Signature Date

Lactation Schedule: _____

Designated Location: _____

_____ _____

Supervisor's Signature Date

_____ _____

Chief Human Resources Officer or Designee Date

Original: Human Resources Copy: Employee Copy: Supervisor