Lactation Accommodation Request Form

In accordance with the County of Monterey Lactation Accommodation While at Work Policy, breastfeeding employees may request and be provided breaks and/or space to express milk during working hours. **Employees are encouraged to submit this completed and signed form to their Departmental Benefit Coordinator as soon as they identify the need for lactation accommodation. If employees are interested in completing the form electronically via DocuSign, please click** here. Providing as much advance notice as possible will assist the County in ensuring that an appropriate location can be identified prior to the employee's need.

Employee Information

Name: ____ Title/Position: _____________________________

Work email: ______________________________________ Work phone: _____________________________

Department/Office location: ____

Lactation Accommodation Request

Start date accommodation needed: ________________ Estimated end date: ________________

Do you need additional time beyond your rest break(s) and/or lunch break to express milk? ☐ Yes ☐ No

- *If **yes**, complete the following section:*

Indicate the additional days/times outside of your regularly scheduled breaks/lunch that you request, including estimated length of break:

☐ Monday	☐ Tuesday	☐ Wednesday	☐ Thursday	☐ Friday	☐ Saturday	☐ Sunday

How do you plan to make up your time (check all that apply)? ☐ Accruals ☐ Flex schedule

☐ Other (explain)

____

By my signature below, I agree to adhere to the County's Lactation Accommodation While at Work Policy*:*

Employee signature ____ Date ________________

Supervisor/Manager Review

Supervisor/Manager Name:	
Title:	
☐ Approved (optional *comments*)	
☐ Denied (required *comments*)	

Supervisor/Manager Signature ____________________________________ Date _________________

If request is denied by supervisor/manager, form must be forwarded to the Department Head for final review.

Department Head Review

Department Head Name:	
Title:	
☐ Approved (optional *comments*)	
☐ Denied (required *comments*)	

Department Head Signature ____________________________________ Date _________________

If approved, return completed form to your Departmental Benefit Coordinator. If the request is denied, a copy of the denial should be forwarded to the Civil Rights Office.