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: ______________________

LACTATION ACCOMODATION 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**
Break 1	Start Time	Start Time	Start Time	Start Time	Start Time	Start Time	Start Time
	End Time	End Time	End Time	End Time	End Time	End Time	End Time
Break 2	Start Time	Start Time	Start Time	Start Time	Start Time	Start Time	Start Time
	End Time	End Time	End Time	End Time	End Time	End Time	End Time

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: ______________________

Supervisor/Manager Title: ______________________

☐ Approved (***optional*** *comments*)

☐ Denied (***required*** *comments*)

Supervisor/Manager Signature: ______________________ Date: __________

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

DEPARTMENT HEAD REVIEW

Department Head Name: ______________________

Department Head Title: ______________________

☐ Approved (***optional*** *comments*)

☐ Denied (***required*** *comments*)

Department Head Signature: ______________________ Date: __________

If approved, return the 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.