BAYLOR UNIVERSITY
Certification of Health Care Provider For
Maternity Leave and Primary Caregiver Affidavit
BU-PP 418A & BU-PP 418B

SECTION I: For Completion by the EMPLOYEE

Your Name: _____
First MI Last BU ID Number

Your Job Title: _____

Please select one:
☐ Maternity Leave (for pregnant female faculty and staff)

☐ Primary Caregiver Leave

_____ _____
Employee Signature **Date**

SECTION II: For Completion by the HEALTH CARE PROVIDER

Provider Name (please print): _____

Phone: _____ Fax: _____

Medical Facts:

1. What is the expected date of delivery? ____ / ____ /____

2. Expected dates of your patient's physical incapacity due to pregnancy and delivery (*not primary caregiver leave)*:

   From (Date): ____ / ____ /____ To (Date): ____ / ____ /____

_____ _____
Health Care Provider Signature **Date**

SECTION III: Primary Caregiver Affidavit – For Completion by the Employee

Name of Child(ren): _____

Date of Birth, Adoption, or Foster Care Placement in Faculty/Staff Member's Home: ____ / ____ /____

By signing below, you certify the following:
I affirm that I am the Primary Caregiver of the newborn child or recently placed child(ren) listed above. I understand that if the child is newly placed, he or she must be under the age of 18, or, in the case of a child who is 18 years of age or older, who is incapable of self-care.

I affirm that the information I have provided in this affidavit is true and correct.

_____ _____
Employee Signature **Date**

When form is complete, please either: Mail to Baylor University, Human Resources, One Bear Place #97053, Waco, TX 76798-7053;
Fax to (254) 710-3819; or Email to askHR@baylor.edu
If you have questions, please contact: (254) 710-2000 or askHR@baylor.edu