820 Grimes Boulevard • Lexington, NC 27292 • 336.249.6688 • Fax: 336.249.6687 • www.partnershipforchildren.org

## *Medical or Maternity Leave—Return-to-Work Form—New Applicants*

In order to determine your eligibility for the Smart Start of Davidson County (SSDC) Child Care Scholarship Program, it is necessary for you to provide proof of the date when you returned to work after your medical or maternity leave. *Please have your **employer** complete this form and submit it with your Child Care Scholarship application. Your **employer** must complete the form for us to use it for processing.*

**1. Employee Name: _____**

**2. Return to Work Date----Proposed: _____ Official:_____**

**3. Upon returning to work from medical or maternity leave, what is the FIRST pay date when this person will have worked for a COMPLETE pay period reflecting his/her TYPICAL pay and hours? _____**

**4. Pay Rate $: _____** □Hourly □Weekly □Biweekly □Twice a Month □Monthly

**5. On average, how many hours will this person be working per week? _____**

**6. How often will the pay be received?** □Weekly □Biweekly □Twice a Month □Monthly

**7. Is this person a 10-month or a 12-month employee? _____**

Name of the Company/Employer: _____

Company/Employer Address: _____City: _____ Zip Code: _____

Phone#: _____ Fax#_____ Contact Email:_____

Employer's Printed Name: _____ Title: _____

Employer's Signature:_____ Date:_____

**FOR SMART START USE ONLY**

**Employment Information Verified by: _____ By: Phone Email Date: _____**

**Employee's Official Return-to Work Date as Verified by Employer: _____**