# COUNTY OF TULARE LACTATION ACCOMMODATION REQUEST

Employee Name:_________________________________________ Date:___________________________

Employee #: ________________________ Employee Job Title:_____________________________________

Department:________________________________ Location:__________________Phone:____________

**APPROXIMATE LACTATION BREAK SCHEDULE**: Please indicate approximate time of day and duration, in minutes, of the break needed. Depending on circumstance, a general length of time required for a session is 20-40 minutes, with a session needed every 2-3 hours.

| **Approximate Time** *(Example: 9:30 AM)* | **Approximate Duration** *(Example: 30 minutes)* |
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1. **TIME USED IN EXCESS OF EMPLOYEE'S NORMAL BREAK SCHEDULE** will be covered/paid by:

   ☐ Accrued Time. Check: _____Vacation _____CTO
   ☐ Unpaid
   ☐ Flex Schedule (If available. Use of a flex schedule will be at the approval of the department head)

2. **LOCATION OF LACTATION ROOM**

   ☐ Dedicated Lactation Room/Space Located at: ________________________________
   ☐ Employee's private and secure office
   ☐ Other:_____________________________________________
   ☐ I am unaware of a reasonable location for accommodation

I have received a copy of and have read the County's guidelines on lactation accommodation and I agree to comply with the guidelines. I understand that if my accommodation needs change, I will submit a new request form. I understand that I will notify my direct supervisor and/or the department human resources representative as soon as I do not require a lactation accommodation.

__________________________________________________ __________________________
Employee's Signature Date

**Department Accommodation Review:** ☐ **Approve** ☐ **Modify To:** ________________________________
☐ **Deny** ________________________________

**Reasons for Modification or Denial:** __________________________________________________________

____________________________________ ____________________________ __________________
Print Name (Dept Authority) Signature (Dept Authority) Date

____________________________________
Title (Dept Authority)

- **Upon Approval, date notification to Payroll, if needed:**_______________
- **Date Employee received copy of Dept Decision of Accommodation Request :**_____________