ST. FRANCIS SCHOOL DISTRICT
FAMILY AND MEDICAL LEAVE REQUEST FORM

I, ________________________________, request family and medical leave for the following
(Name of Employee)
reason:

Check the appropriate box:

☐ The birth of my son or daughter and to care for such child;

☐ The placement of a son or daughter with me for adoption;

☐ The placement of a son or daughter with me for foster care;

☐ To care for my (**circle one**) spouse, son, daughter, parent or parent-in-law who has a serious health condition; or

☐ My serious health condition.

Schedule of Leave

I will be absent from work from ____________________ to ________________________

OR

On the following dates: ____

I understand that if my leave is approved, my time away from work will be charged against my leave entitlement under the Wisconsin and/or Federal FMLA.

Health Care Provider Certification

If your leave request is due to a serious health condition, please have a Health Care Provider Certification form completed by a Health Care Provider. I understand that the Health Care Provider Certification form should be returned to the Human Resources Department within fifteen (15) days after receiving the Certification form. If I am not able to return the form within fifteen (15) days, I will contact the Human Resources Department before the fifteen (15) days have passed and request assistance.

Health Care Provider (provide information below):

Name: ___________________________ Phone: ____________________

Address: ____

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By the execution of this Request form, I hereby authorize the Health Care Provider listed above to provide such information to the District as its agent may request relative to the information required in the Health Care Provider Certification form of the District without liability for the release of such information. I understand a separate consent may be necessary if the certification is for my spouse or parent.

Medical Certification

I understand that if I am requesting medical leave for my serious health condition or the serious health condition of my spouse, parent, parent-in-law, son or daughter, I must provide the company with a Health Care Provider Certification form. While I am on leave, I understand I must provide the company with a Recertification and Intent to Return to Work form on a periodic basis. If the medical leave was due to my own serious health condition, and my leave was for more than five (5) days, I must also provide the company with a Fitness-for-Duty Certification form, completed by the Health Care Provider, before my return to work. I understand that my failure to provide the Fitness-for-Duty Certification form may result in my being denied reinstatement until such certification is provided to the District.

In the event that I desire to return to work prior to the expiration of my leave, I will notify the District at least one (1) working day prior to my desired return date. If I return early, the District will attempt to place me in my former position or an equivalent position until the expiration of the time of my initial leave.

Premium Recovery

I understand and agree that if I fail to return to work at the expiration of my leave, I will be liable to the District for any health and dental coverage premiums paid on my behalf during the leave.

Substitution of Leave

If I am taking leave for the birth or placement for adoption or foster care of my son or daughter, or the serious health condition of my son, daughter, spouse, parent or parent-in-law, I understand I may request payment for any accrued leave to which I am entitled at the time of my leave under the District's leave policies, or I may be paid by the District as authorized by law. When paid leave is substituted for unpaid leave, the paid leave will not be available to me later.

I understand that the use of any accrued leave for my family and medical leave will not extend or result in additional family and medical leave being available to me. The family and medical leave will run concurrently with any leave used.

If I have any questions or require the forms necessary to comply with the requirements of the District's Family and Medical Leave Policy, I must contact the Human Resources Department in the District Office.

Dated this ___________ day of ____________________, 20____.

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Employee's Signature