



EMPLOYEE REQUEST FOR FMLA / MEDICAL LEAVE OF ABSENCE

Please return this form directly to Melissa Beck in the Human Resource Department

TO BE COMPLETED BY THE EMPLOYEE:	
Employee Name: _____	
Home Address: _____	
Home Phone: _____	Email: _____
<p>_____ Time for my own serious health condition <i>You must have the health care provider complete the appropriate sections of the Certification form for your serious health condition.</i></p>	
<p>_____ Birth of my child or Placement of a child with me for adoption or foster care Anticipated date of birth, adoption or placement: _____ <i>You must provide the appropriate documentation showing date of adoption or placement</i></p>	
<p>_____ To care for a family member with a serious health condition Family member's name: _____ Relation: _____ Age: _____ <i>You must have the health care provider complete the appropriate sections of the Certification form for the family member's serious health condition.</i></p>	
<p>_____ To care for a service member with a serious health condition <i>You must submit the Certification of Serious Injury or Illness of Covered Service Member for Military Leave form.</i></p> <p>_____ Active duty exigency Family member's name: _____ Relation: _____ Age: _____ <i>You must have the health care provider complete the Certification of Qualifying Exigency for Military Family Leave form.</i></p>	
Anticipated Begin Date of Leave: _____	Anticipated Return to Work: _____
If Leave will be taken intermittently or on a reduced schedule, indicate anticipated schedule below: _____	
Do you wish to substitute paid leave for any portion of <u>WI Family or Medical Leave</u> : <input type="checkbox"/> Yes Sick Leave Hours _____ Comp Time Hours _____ Vacation Hours _____ <input type="checkbox"/> No	
Does your spouse work for the School District of Menomonee Falls? <input type="checkbox"/> Yes <input type="checkbox"/> No	
I understand and agree that my request for Federal and/or WI FMLA leave is approved contingent upon my providing appropriate medical documentation or other required certification within 15 days of my receipt of this form to support this leave. Upon approval, the time off will be applied retroactively towards the total leave time allowed by law.	
Employee Signature: _____ Date: _____	