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EMPLOYEE REQUEST FOR FMLA / MEDICAL LEAVE

Human Resources
W156N8480 Pilgrim Road
Menomonee Falls, WI 53051
Fax: 262-250-6494
Ph: 262-255-8396

To request leave on the basis of the Family and Medical Leave Act (FMLA), please complete the following request form and submit to Human Resources at least 30 days prior to leave (unless leave is unforeseen, in which case submit the form as soon as practical).

Employee Name: _____

Work Location and Job Title: _____

Home Phone: _____

Email: _____

_____ **Time for my own serious health condition**

You must have the health care provider complete the appropriate sections of the Certification form for your serious health condition.

_____ **Birth of my child or Placement of a child with me for adoption or foster care**

Anticipated date of birth, adoption or placement: _____

_____ **To care for a family member with a serious health condition**

Family member's name: _____

Relation: _____

Age: _____

_____ **To care for a service member with a serious health condition**

_____ **Active duty exigency**

Family member's name: _____

Relation: _____

Age: _____

If leave is to be continuous indicate anticipated dates below:

Anticipated Begin Date of Leave: _____ Expected End Date of Leave: _____

If Leave will be taken intermittently or on a reduced schedule, indicate anticipated schedule below:

Do you wish to apply paid leave for any portion of WI Family or Medical Leave:

Yes Sick Leave Hours _____ Comp Time Hours _____ Vacation Hours _____

No

Does your spouse work for the School District of Menomonee Falls? Yes No

Determination of eligibility for leave under FMLA, and/or additional documentation or clarification of documentation, may be required prior to making a final FMLA determination to approve or deny an FMLA leave request. Please contact Human Resources with any questions.

Employee Signature: _____ Date: _____