NEENAH JOINT SCHOOL DISTRICT
Neenah, Wisconsin

NEENAH JOINT SCHOOL DISTRICT FAMILY AND MEDICAL LEAVE REQUEST FORM

DATE: _____

EMPLOYEE'S NAME: _____

SCHOOL: _____

(Please read all attachments carefully)

TYPE OF LEAVE REQUESTED:
(Check all that pertain to your request)

_____ **Wisconsin Family Medical Leave Act (WFMLA) - 12 month calendar year period.**
- This Act allows for substituting any personally accrued paid leave to offset salary loss during leave.

_____ **A) Birth, adoption, or foster care**
- Leave must be taken within the 16 week period preceding or following the birth, adoption, or foster care placement. Intermittent leave will only be permitted during this period of time.
- This leave must conclude within 12 months of the birth or placement.

_____ **B) A serious health condition that makes you unable to perform the essential functions of your job.**

_____ **C) A serious health condition affecting your:**
- ____ **spouse, for which you are needed to provide care.**
- ____ **child, for which you are needed to provide care. (date of birth _____)**
- ____ **parent or parent –in-law, for which you are needed to provide care.**

_____ **Federal Family and Medical Leave Act (FFMLA) – 12 month calendar year period**
- This Act does not allow for any substitution of personally accrued paid leave to offset lost salary unless otherwise authorized for such paid leave; however your benefits and seniority continue.
- Leave must be taken within the 12 month period following the date of birth or placement.

_____ **A) Birth, adoption, or foster care.** (Intermittent leave is permitted only as set forth above.)

_____ **B) A serious health condition that makes you unable to perform the essential functions of your job.**

_____ **C) A serious health condition affecting your:**
- ____ **spouse, for which you are needed to provide care**
- ____ **child, for which you are needed to provide care. (date of birth _____)**
- ____ **parent, for which you are needed to provide care.**
- ____ **service member, for which you are needed to provide care.** Additional 12 weeks of leave available, max of 26 weeks in a 12 month period. FMLA starts from date of leave.

_____ **D) Exigency leave**

- **You are required to provide a Health Care Provider certification form within fifteen (15) days of the date of this request form.**

LENGTH OF LEAVE TIME REQUESTED: State beginning date and ending date, if leave is requested to be intermittent, state projected intermittent dates (Intermittent leave means taking leave in blocks of time, or by reducing normal weekly or daily work schedules. When intermittent leave is needed to care for an immediate family member or the employee's own illness, and is for planned medical treatment, the employee must try to schedule treatment so as not to unduly disrupt the employer's operations.)

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Employee Signature: _____

Return this form to Victoria L. Holt, Director of Secondary Education and Human Resources, prior to the commencement of requested leave. You may be requested to submit a medical certification for this request.