

# NEENAH JOINT SCHOOL DISTRICT

Neenah, WI

## NEENAH JOINT SCHOOL DISTRICT FAMILY AND MEDICAL LEAVE REQUEST FORM

EMPLOYEE NAME: \_\_\_\_\_ DATE: \_\_\_\_\_

SCHOOL: \_\_\_\_\_ POSITION: \_\_\_\_\_

(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 substitution of any personally accrued paid leave to offset salary loss during leave.

\_\_\_\_\_ **A) Birth, adoption, or foster care**

- Leave must be taken within 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 Medical Leave Act (FFMLA) – 12 month calendar year period**

- This Act also allows for substitution of personally accrued paid leave to offset lost salary; your benefits and seniority continue.
- Leave must be taken within 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 or parent-in-law, 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**

- **A Health Care Provider Certification form may be required within fifteen (15) days of the date of this request form.**

**LENGTH OF LEAVE TIME REQUESTED:** State beginning 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, Assistant District Administrator of Human Resources & Instructional Support Services, prior to the commencement of requested leave. You may be requested to submit a medical certification for this request.