



SCHOOL DISTRICT OF

Reedsburg

FAMILY AND MEDICAL LEAVE REQUEST

Name: _____

Start Date of Leave: _____ Return to Work Date: _____

Amount of Leave Requested: _____(number of weeks) _____(number of days) _____(number of hours)

Reason for Leave:

- Birth of child, and to care for that child
Date of birth: _____
- Placement with the employee of a child for adoption or foster care
Date of adoption or placement: _____
- Serious Health Condition of:*
 - Employee
 - Spouse Name: _____
 - Domestic Partner Name: _____
(Wis. FMLA only)
 - Child Name: _____
 - Parent Name: _____
 - Parent of Spouse or Domestic Partner Name: _____
(Wis. FMLA only)
- Military exigency*
- Care of military personnel:* relationship to military personnel _____
- Other: _____
(Please explain)

*A leave request for your own serious health condition, the serious health condition of a family member, or for care of military personnel will require a Health Care Certification Form to be completed by a health care provider. This form will be provided by Human Resources, Mechelle Thompson and you must return the completed form within 15 days. In addition, a leave request for a military exigency may require a certification of active duty or call to active duty.

I understand that if my leave qualifies as family and medical leave, my time away from work will count against my entitlement to both state and federal FMLA leave.

Employee Signature: _____

Date: _____

Date received by Human Resources: _____