

BRILLION PUBLIC SCHOOLS

POLICY 532.31

Form A

Family and Medical Leave Request

<input type="checkbox"/> For office use only Full Time Part Time Average Hours Worked Per Week _____ Employed 1 Year or More Employed Less Than 1 Year
--

Name: _____

Department: _____

Date: _____

1. When did you initially contact _____ (“Employer”) regarding your request for leave of absence? _____
2. Whom did you contact? _____
3. How was the person contacted? (*Please circle one*): Phone In writing Other

I hereby request a leave of absence under the federal and Wisconsin Family and Medical Leave Laws.

The leave of absence is requested for the following reason (check the appropriate box):

1. The birth of my son or daughter and to care for such child;
2. The placement of a son or daughter with me for adoption or foster care;
3. To care for my spouse, son, daughter, parent or parent-in-law (circle one) who has a serious health condition. (Please identify the age of child: _____);
4. My serious health condition;

I will be/was absent from work from _____ to _____.

Note: If the Employer has information that you qualify for Family and/or Medical Leave, your absence will be so classified unless notice is provided otherwise.

If you checked box 3 or 4, please have a Health Care Provider Certification completed by the Health Care Provider or Christian Science Practitioner indicated below and returned to the District Office within fifteen (15) calendar days of your request for leave.

Health Care Provider/Christian Science Practitioner:

Name _____

Telephone No. _____

Address _____

Return to Work Certification

I understand that if I am requesting medical leave for my serious health condition, I must not only provide the Employer with a certification from my health care provider as to the facts surrounding my serious health condition, but must also provide the Employer, prior to my return to work, with a Fitness for Duty Certification which has been completed by my physician. I understand that failure to provide the Fitness for Duty Certification may result in my being denied reinstatement until such document is provided to my supervisor or the District Office. I understand that the Fitness for Duty Certification Form is available from the District Office.

In the event that I desire to return to work prior to the expiration of my leave, I will notify the Employer at least two (2) working days prior to my desired return date.

Alternative Position During Leave

I understand and agree that if my leave is requested to be taken on a reduced or intermittent basis and I am capable of performing work during my requested leave, the Employer may place me in alternative employment within the Employer and I hereby agree to such placement. I understand that the position that I may be placed in may have no relation to my current job responsibilities and that such placement is only temporary. I will be returned to my position or substantially equivalent employment upon the expiration of my leave, if otherwise eligible for reemployment.

If you are requesting intermittent or reduced leave for the birth, adoption or foster care of a son or daughter, please provide a schedule of leave. The Employer will notify you if it agrees with your intermittent or reduced leave proposed schedule.

Dated this _____ day of _____, 20_____.

Employee's Signature

Print Name: _____

Reviewed: 7/20/09