

REQUEST FOR FAMILY MEDICAL LEAVE

Employee Name: _____

Department: _____

Employment Hire Date: _____

Hours Per Week: _____

REASON FOR LEAVE:

Birth/Adoption/Foster Care (Up to twelve (12) weeks unpaid leave, in a twelve (12) month period beginning with any leave approved under this policy, commencing no earlier than the event and ending no later than one (1) year after the event.)

Birth of Child Date or expected date of birth: _____

Placement of child for adoption/foster care Date of placement of child: _____

Required: Attach documentation from an adoption agency/foster care agency to support the facts, thirty (30) days prior to start of leave.

Serious Illness of Employees Child, Spouse, or Parent (up to twelve (12) weeks unpaid leave, in a twelve (12) month period beginning with any leave approved under this policy to care for a child, spouse, or parent with a “serious health condition”).

Child Name: _____ Age: _____ Disabled: Yes No

Spouse Name: _____

Parent Name: _____

Required: Attach an original copy of “Certification of Healthcare Provider” form available in the County Administrator’s office. NOTE: Caretaking Leave shall terminate prior to the approved time schedule in the event that the need for the leave ceases.

For My Own Serious Illness (up to twelve (12) weeks unpaid leave in a twelve (12) month period beginning with any approved leave under this policy for the employee’s own serious health condition). *Required:* Attach an original copy of “Certification of Healthcare Provider” form available in the County Administrator’s office.

National Defense Authorization Act (NDAA)

Qualifying Exigency (Up to twelve (12) weeks unpaid leave, in a twelve (12) month period beginning with any leave approved under this policy, beginning no earlier than the event .) *Required:* Attach certification of call to active duty, form available in the County Administrator’s Office.

Child Spouse Parent Next of Kin: Name: _____

Serious Illness of Employees Servicemember Child, Spouse, or Parent (Up to twenty six (26) weeks unpaid leave, in a twelve (12) month period beginning with any leave approved under this policy, beginning no earlier than the event to care for a child, spouse, parent, or next of kin that is a covered servicemember with a serious injury/illness

incurred in the line of duty.) *Required:* Attach an original copy of "Certification of Healthcare Provider" form available in the County Administrator's office.

Child Spouse Parent Next of Kin: Name: _____

GENERAL INFORMATION:

1. Beginning Date of Leave: _____ 2. Ending Date of Leave: _____

3. Do you need to be completely absent from work during this period? YES NO

If no, how many hours will you need to be absent from work:

Per day: _____ Per week: _____

Total time requested: _____ days _____ weeks _____

4. For birth/adoption/foster care you may take the first 6 weeks paid or unpaid after that you must use all accumulated, unused sick leave, vacation or compensatory leave available to you. For your own or family member serious health condition you may take the first 2 weeks paid or unpaid after that you must use all accumulated, unused sick leave, vacation or compensatory leave available to you.

List the accrued paid leave you choose to use and the appropriate days of usage:

Accrued Paid Leave:	Date:	Total Hours:
_____	_____	_____
_____	_____	_____
_____	_____	_____

5. Please add any general comments that pertain to this leave request:

I UNDERSTAND THAT:

1. This request, if approved, will be counted against my Family and Medical Leave Act annual entitlement.
2. If I do not return to work on the date indicated or have not applied for an extension by such date, I will be considered as voluntarily resigning my position with Kewaunee County. However, I am entitled to return to the same or equivalent position.
3. If the leave is due to my own illness, I will be required to submit a "Certification of Healthcare Provider Form" (within 15 days of receiving the form) and a "Return to Work Certification" prior to my return to work.
4. I may substitute specified paid leave time during the period in which the leave is approved.
5. If I wish to continue my existing health and dental insurance coverage, I must pay the employee's share of the premium. I will make the necessary arrangements with the County Administrator. However, if I fail to return from unpaid leave, Kewaunee County may take action to recover its share of the premiums paid during my leave.

Employee's Signature: _____ Date: _____

Department Review

Department Head Signature: _____ Date: _____

County Administrator Review

Employee has worked 1250 hours in the last twelve (12) months YES NO

Approved

Disapproved – Reason: _____

County Administrator Signature: _____ Date: _____
