Oak Creek-Franklin Joint School District
FAMILY AND MEDICAL LEAVE - EMPLOYEE REQUEST

Name _____ Date _____

Address, City, State, Zip _____ Employee Phone # _____

Building _____ Current Position _____

Anticipated Leave Begin Date _____ Anticipated Return to Work Date _____

☐ Intermittent Leave absence (list dates) _____

REASON FOR LEAVE (Check all applicable)

☐ Birth

☐ Foster/Adoption Placement

☐ Employee's Own Serious Health Condition

☐ To Care for Family Member (check one)

☐ Spouse ☐ Son/Daughter ☐ Parent ☐ Parent-in-Law

☐ Serious illness of my domestic partner

☐ Serious illness of parent of domestic partner

☐ Military Exigency

Substitution of Paid Leave: If an employee has Paid Time Off or Sick Leave Pay available, it will be used for all absences.

☐ Paid Time Off (# of Days) _____

☐ Sick Leave Pay (# of Days) _____

☐ Unpaid Leave (# of Days) _____

Please attach documentation from the health care provider that certifies the serious health condition (you may use the Physician or Practitioner Certification on Page 2 of this form).
The District may request additional documentation in order to approve this request.
If you are unable to return on the date noted, you must notify the Director Of Human Resources prior to that date.

For questions regarding completion of the application, please contact the Director of Human Resources at 768-6155.

Employee's Signature _____ Date: _____

Administrator's Signature _____ Date: _____

Physician or Practitioner Certification
(to be completed by Physician)

For Family or Medical Leave Personal information you provide may be used for secondary purposes. See Sec. 15.04 (1) (m), Wis. Stats., for details.

Dear Physician or Practitioner:
To assist in establishing leave entitlements under the Wisconsin Family and Medical Leave Act (Section 103.10, Wisconsin Statutes) please answer the questions checked below and return this certification form to the employer listed below.

Employer Information:

Employer Name: Oak Creek Franklin Joint School District
Address: 7630 S 10th Street, Oak Creek, WI 53154 FAX: 414-768-6172

Employee/Patient Name

Employee Name _____

Patient Name (if not employee) _____

Does the employee or patient listed above have a serious health condition? _____Yes _____ No
Note: *The Wisconsin Family and Medical Leave Act (Section 103.10, Wisconsin Statutes) defines a* ***serious health condition*** *as a disabling physical or mental illness, injury, impairment or condition involving either inpatient care in a hospital, or outpatient care that requires continuing treatment or supervision by a health care provider.*

What date did the condition begin? _____

What is the probable duration of the condition? _____

Briefly describe the serious health condition (an exact diagnosis is not required). _____

_____

_____

_____

_____

_____

Please indicate the extent to which the employee is unable to perform his or her employment duties: _____

Physician/Practitioner Information

Physician/Practitioner Name (Please Print) _____

Signature of Physician/Practitioner _____ Date Signed _____