SCHOOL DISTRICT OF AMERY
EMPLOYEE REQUEST FOR FAMILY AND/OR MEDICAL LEAVE

SECTION 1: Employee Information *(School District employee requesting leave)*

Name:

Address:

Home Phone: | E-mail:

School Building/Dept:

Reason for Leave Request: *(Check all that apply)*

- ❑ Birth/Adoption/Pre-Adoptive Foster Care
- ❑ Foster Placement
- ❑ Employee's Own Serious Health Condition *(may require medical certification)*
- ❑ To Care for Family Member of Military Service member with Serious Health Condition***** *(may require medical certification)*
- ❑ For a Qualifying Exigency due to the military active duty status or call to active duty status of a spouse, son, daughter or parent *(certification may be required)*

When FMLA is needed to care for a family member or service member, you must state the care you will provide and an estimate of the time period during which this care will be provided, including a schedule of intermittent leave or leave on a reduced work schedule, if requested.

Anticipated Start Date of Leave:

Anticipated End Date of Leave:

Briefly Explain Reason for Leave *(if leave is to care for someone, indicate the name of, and relationship to, the person who needs care. If leave is to care for a domestic partner or a domestic partner's parent(s), complete and sign the back of this form.)*

Substitution Of Paid Leave: *Please indicate if you would like to use paid or unpaid leave during your absence (to the extent provided by law and District policy) and how many days you plan to use (to the extent provided by law). Attach an additional leave worksheet if needed.*

- ❑ Sick Leave *(Certified Staff)* (_____ Days)
- ❑ PLT *(Support Staff)* (_____ Days)
- ❑ Personal Leave *(Certified Staff)* (_____ Days)
- ❑ Vacation *(Admin/Support Staff)* (_____ Days)
- ❑ Emergency Leave *(Certified Staff)* (_____ Days)
- ❑ Other:_____ (_____ Days)

I authorize the appointing authority to obtain any necessary information regarding my request for FMLA leave.

Employee Signature:_____ Date:_____

~Submit completed form to the District Office~

SECTION 2: For completion by the EMPLOYEE who is taking leave to care for a domestic partner or a domestic partner's parent(s) ONLY

Effective June 30, 2009, employees are allowed to take up to two weeks WFMLA leave to care for a domestic partner or a domestic partner's parent(s) who is suffering from a serious medical condition. Employees can exercise this right under WFMLA as either a registered or unregistered domestic partner.

In order to be eligible to take WFMLA leave under these provisions, you must satisfy one of the two following sets of requirements. Please check the box that applies to your domestic partnership.

❑ I have a **registered domestic partnership** with the Register of Deeds for the county in which my domestic partner and I reside. In order to certify my domestic partnership, I have certified the following with the Register of Deeds:

We are both at least 18 years old and capable of consenting to the domestic partnership;
Neither of us is married to, or in a domestic partnership with, another individual;
We share a common residence;
We are not nearer of kin to each other than second cousins, whether of the whole or half blood or by adoption; and
We are of the same gender.

❑ I am in an **unregistered domestic partnership**. I am in a relationship with another individual and we satisfy the following requirements:

We are both at least 18 years old and otherwise competent to enter into a contract;
Neither of us is married to, or in a domestic partnership with, another individual;
We share a common residence;
We are not related by blood in any way that would prohibit marriage under the Wisconsin law;
We consider ourselves to be members of each other's immediate family, and
We agree to be responsible for each other's basic living expenses.

Certification of Domestic Partnership for WFMLA Purposes Only:

I certify that _____ is my domestic partner.
(Name of Domestic Partner)

Employee Signature:_____ Date:_____

~Submit completed form to the District Office~

For District Office Use Only

Leave Request is: ❑ Approved for *(circle)* WFMLA FMLA Both
❑ Not Approved *(explain below)*

Authorized Authority Signature:_____ Date:_____