



# COUNTY OF KENOSHA

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## FAMILY AND MEDICAL LEAVE REQUEST

Name: \_\_\_\_\_ Original Hire Date: \_\_\_\_\_  
Telephone \_\_\_\_\_ Full Time:   
Number: \_\_\_\_\_ Part Time:   
Department/ \_\_\_\_\_  
Division: \_\_\_\_\_

When did you contact the County regarding your leave of absence? \_\_\_\_\_

Who did you contact? \_\_\_\_\_

I hereby request a leave of absence under the Federal and Wisconsin Family and Medical Leave Laws. The leave of absence is for the following reason (check the appropriate box):

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

**I will be/was absent from work on the following days** \_\_\_\_\_.

**I will return to work on** \_\_\_\_\_.

Note: If the County 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 (pages 3 –6) completed by the Health Care Provider or Christian Science Practitioner indicated below and returned to the Division of Personnel Services within fifteen (15) days of your request for leave.*

Health Care Provider/Christian Science Practitioner:

Name \_\_\_\_\_ Telephone No. \_\_\_\_\_

Address \_\_\_\_\_

By execution of this request form, I hereby authorize the Health Care Provider, as my spokesperson, to provide such information and medical records as requested by the County without any liability for such release of information.



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## **Return to Work Certification**

I understand that if I am requesting medical leave for my serious health condition, I must not only provide the County with a certification from my health care provider as to the facts surrounding my serious health condition, but must also provide the County, prior to my return to work, with a Release to Return to Work which has been completed by my physician. I understand that failure to provide the Release to Return to Work Certification may result in my being denied reinstatement until such document is provided to my supervisor or the Division of Personnel Services.

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

## **Benefits**

I understand that during my period of leave, if applicable, I must continue to pay the employee portion of the costs of benefits continued during the leave. If I do not pay the required premium, my benefits, including my group health plan coverage, will be terminated.

## **Alternate 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 County may place me in alternative employment within the County 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.

## **Intermittent or Reduced Leave**

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 County will notify you if it agrees with your intermittent or reduced leave proposed schedule.

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I understand and will comply with the conditions stated above:

Dated this \_\_\_\_\_ day of \_\_\_\_\_, 20\_\_\_\_\_.

\_\_\_\_\_  
Employee's Signature

Print Name: \_\_\_\_\_



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(Before submitting this form, please detach the Family and Medical Leave Policy Notice of Rights on pages 9 and 10 and retain for your records.)

## FAMILY AND MEDICAL LEAVE REQUEST HEALTH CARE PROVIDER CERTIFICATION

Employee Requesting Leave: \_\_\_\_\_

I, \_\_\_\_\_, confirm that \_\_\_\_\_  
(Name of Health Care Provider) (Patient's Name)

is under my care for an illness or injury, impairment or physical or mental condition involving (*check the appropriate box*):

- Inpatient care in a hospital, hospice or residential medical facility
- Any period of absence which:
  - Renders the person incapable of performing work, school attendance, or other regular activities
  - Is more than three (3) calendar days
  - Involves continuing treatment or supervision by a health care provider
- Continuing treatment by (or under the supervision of) a health care provider for a chronic or long-term health condition that is incurable or so serious that it may result in a period of incapacity of more than three (3) calendar days
- Prenatal care

**In addition, I certify that the patient is one of the following (*check the appropriate box*):**

- An employee of the County
- The spouse of an employee
- The son or daughter of an employee
- The parent or parent-in-law of an employee

**Accordingly, I certify that:**

The health condition commenced on \_\_\_\_\_, 20\_\_\_\_, and has probable duration through \_\_\_\_\_, 20\_\_\_\_\_.

The patient was first seen by me relative to, and treated for, this condition on \_\_\_\_\_.



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I have provided care to the patient on the following date(s). (List all dates of treatment or supervision):

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The patient is incapable of work, attending school or performing activities of daily living on the following dates (*for the specified parts of such days*):

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The patient was treated on an inpatient/outpatient basis (*circle which is applicable*).

The medical facts regarding the health condition are as follows, including the treatment associated with the condition (*if an outpatient, please state whether there was a regimen of continuing treatment involving prescription medication and/or treatment and for that period of time said treatment is/was required*):

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Was the procedure/treatment scheduled in advance or an emergency basis? *If scheduled in advance, please indicate how many days in advance the treatment was scheduled.* \_\_\_\_\_

Scheduled in advance

Emergency Basis



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**If the patient is an employee: the health condition must render the employee unable to perform the functions of his or her position which means the employee is unable to work at all or unable to perform the essential functions of the position.**

I am aware of the job functions required for this employee to perform the duties of the employee's position. The following functions may be performed by the employee:

**Yes    No**

- |                          |                          |  |
|--------------------------|--------------------------|--|
| <input type="checkbox"/> | <input type="checkbox"/> | Standing for 30 minutes or less  |
| <input type="checkbox"/> | <input type="checkbox"/> | Standing for more than 30 minutes but less than 2 hours (with or without breaks) |
| <input type="checkbox"/> | <input type="checkbox"/> | Standing for more than 2 hours (with or without breaks)                          |
| <input type="checkbox"/> | <input type="checkbox"/> | Sitting for 30 minutes or less   |
| <input type="checkbox"/> | <input type="checkbox"/> | Sitting (with or without breaks) for more than 30 minutes but less than 2 hours  |
| <input type="checkbox"/> | <input type="checkbox"/> | Sitting (with or without breaks) for 2 hours or more                             |
| <input type="checkbox"/> | <input type="checkbox"/> | Walking short distances (20 yards)   |
| <input type="checkbox"/> | <input type="checkbox"/> | Arm movement (if limited, please note below)                                     |
| <input type="checkbox"/> | <input type="checkbox"/> | Lifting 20 or more pounds  |
| <input type="checkbox"/> | <input type="checkbox"/> | Lifting less than 20 pounds  |
| <input type="checkbox"/> | <input type="checkbox"/> | Talking  |

Below is an explanation of the extent to which the employee is unable to perform the functions of the position as a result of the health condition.

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If the employee requires intermittent (leave taken in blocks of time) or reduced leave (leave that reduces the employee's hours per workweek or workday) which is **medically necessary**, please describe why the intermittent or reduced leave is medically necessary, the dates on which treatment is expected, and the expected duration of the treatment and leave.

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If the patient is the spouse, son, daughter, parent or parent-in-law of the employee: the health condition of such individual must require that the employee is needed to care for such individual. A health condition for such individual must be such that affects an individual's ability to engage in normal daily activities.

- The employee will be needed to care for the spouse, parent, son or daughter on the following dates: \_\_\_\_\_

*(Please indicate which portion of such days will be required for care, i.e., hours needed for care:*

\_\_\_\_\_)

- Son or daughter's date of birth: \_\_\_\_\_
- Describe the care to be provided by employee: \_\_\_\_\_

\_\_\_\_\_

- If the employee requires intermittent (leave taken in blocks of time) or reduced leave (leave that reduces the employee's hours per workweek or workday) to care for the employee's spouse, parent, son or daughter, please describe why it is necessary, the schedule of treatment and the duration.

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Dated this \_\_\_\_\_ day of \_\_\_\_\_, 20\_\_\_\_\_.

\_\_\_\_\_  
Signature of Health Care Provider/ Christian  
Science Practitioner

\_\_\_\_\_  
Telephone Number

\_\_\_\_\_  
Address

\_\_\_\_\_  
City/State



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(To be completed by the employee.)

## MEDICAL AUTHORIZATION AND RELEASE

I, \_\_\_\_\_, hereby authorize the above-referenced health care provider, or others to whom I am directed for care relative to the health condition set forth above, to confer with medical representatives of the County to clarify or supplement any information set forth herein without liability.

Dated this \_\_\_\_\_ day of \_\_\_\_\_, 20\_\_\_\_\_.

\_\_\_\_\_  
Sign Name

\_\_\_\_\_  
Print Name



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(To be completed by Health Care Provider. Complete only if Family and Medical Leave is for the employee's serious health condition.)

## **FAMILY AND MEDICAL LEAVE POLICY RELEASE TO RETURN TO WORK**

I certify that \_\_\_\_\_, as of \_\_\_\_\_, 20\_\_\_\_, no longer suffers from the serious health condition for which Family and Medical Leave was requested from Kenosha County and is able to return to work to perform all of the functions of his/her position without restriction.

Dated this \_\_\_\_\_ day of \_\_\_\_\_, 20\_\_\_\_\_.

\_\_\_\_\_  
Signature of Health Care Provider or  
Christian Science Practitioner



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(Note: Employee is to retain this and the following page for their records)

## FAMILY AND MEDICAL LEAVE POLICY NOTICE OF RIGHTS

The following information concerns your rights and obligations under the family and medical leave law and will explain the consequences of your failure to meet these obligations. Please read the information carefully, and if you have any questions, please contact your supervisor or the Division of Personnel Services.

1. **Leave Entitlement.** The actual amount of time you spend on family and/or medical leave will be subtracted from your 12 workweeks of unpaid leave entitlement. Family and Medical Leave for your own serious illness will run concurrently with any similar leave provided for in the labor agreement, e.g. accident & sickness (A & S) leave, pregnancy leave, etc.
2. **Medical Certification.** If your leave is based on your serious health condition or the serious health condition of your child, spouse or parent, you must provide the County with a medical certification prepared by your health care provider: (the Health Care Provider Certification). The medical certification must be provided to the County within fifteen (15) calendar days of its request, or in cases of medical emergency or unforeseen circumstances, as soon as practicable after your leave begins. If you fail to provide a timely Certification, your leave request, or your continuation of leave, may be denied until the required Certification is provided.
3. **Additional Certifications.** If the County has any doubts about the accuracy of your initial medical certification, you must submit to another examination, at the County's expense, by a health care provider selected by the County. If the second opinion differs from the initial certification, a third opinion may be required. The third opinion is final and binding.
4. **Recertification.** You must provide the County with recertification on a periodic basis that your serious health condition still prevents you from performing your job functions or that you are still needed to care for a family member with a serious health condition.
5. **Intent to Return to Work.** You must provide the County with a periodic report on your status and intent to work.



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6. **Release to Return to Work.** If you are on medical leave because of your own serious health condition, you must provide the County with a Release to Return to Work, signed by your health care provider, before you can return to work. If you fail to provide the County with such Certification, your reinstatement will be denied until the required certification is provided.
7. **Substitution.** You may have the option of substituting certain types of paid leave for unpaid family and/or medical leave pursuant to the County's FMLA Policy. When paid leave is substituted for your unpaid leave, the paid leave will not be available to you later.
8. **Maintenance of Health Insurance Coverage.** In order to maintain your group health coverage during your family or medical leave you must continue to pay your share of the health insurance premiums (if applicable), as you did prior to your leave. If you elect to substitute paid leave, or if the County requires the substitution of paid leave, your share of premiums will be paid through the County's normal payroll deduction method. Otherwise, the County will designate a method for collecting premiums when your leave is unpaid.
9. **Employment Protection.** Upon returning to work from family or medical leave, you will be reinstated to the position you held prior to leave or, if your position is no longer available, to an equivalent position with equivalent pay, benefits, and other terms and conditions of employment unless your employment would otherwise have ceased. You will have no greater right to employment at the end of you leave than you would have had with the County if you had not taken leave.
10. **Recovery of Premiums.** If you fail to return to work after your family and medical leave, you will be required to reimburse the County for any health insurance premiums paid on your behalf during your leave.