



COUNTY OF KENOSHA

Family and Medical Leave Request Form

Name: _____ Department/Division: _____

Phone: _____ Original Hire Date: _____ Full or Part Time: _____

Reason and Type of Leave Requested:

Check One:

Self _____ Spouse/Domestic Partner _____ Child _____ Parent/Parent in Law _____

Check One:

Birth _____ Adoption _____ Serious Illness _____ Military _____

Start Date of Requested Leave _____ **Date of Return to Work** _____

Start Date of Intermittent Leave _____ **End Date for Intermittent** _____

Family and Medical Leave is without pay. An employee will be charged accrued vacation for Federal Family and Medical Leave. An employee may, however, elect to substitute accrued vacation or Paid Time Off (PTO) for State Family and Medical Leave. Do you wish to do so?
Yes/No _____

An employee requesting leave, except for the birth of a child, must submit the Family and Medical Leave Physician or Practitioner Certification Form.

If your leave schedule is not yet known or other arrangements are necessary, please explain what must be done before your schedule can be confirmed. _____

If you are requesting intermittent leave, please attach a schedule. Leave may be taken in the smallest increment allowed by your department/division for any other non-emergency leave.

You must notify your supervisor that you have requested a Family and Medical Leave and the dates of such leave.

If you are unable to return on the date noted, you must notify your supervisor prior to such date.

Employee Signature: _____ Date Signed: _____



COUNTY OF KENOSHA

Family and Medical Leave Physician or Practitioner Certification Form

Dear Physician or Practitioner:

To assist in establishing leave entitlements for Kenosha County employees under State and Federal Family and Medical Leave laws, please answer the following questions and return or fax this certification form to Kenosha County Division of Personnel Services at (262) 653-2463.

Employee/Patient (if not employee) Name: _____

1. Does the above named patient have a serious health condition? Yes _____ No _____

(A serious health condition in Wisconsin Statutes is defined 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.)

2. The health condition commenced on _____, 20____, and has a probable duration through _____, 20_____.

3. The medical facts regarding the health condition including the treatment associated with the condition are as follows: _____

4. Indicate the extent to which the employee is unable to perform his/her job duties: _____

5. If the employee requires intermittent or reduced leave (leave that reduces the employee's hours per work week or work day) describe why it is necessary, the schedule of treatment and the duration: _____

Physician/Practitioner Name: _____

Physician Signature: _____ Date: _____