



Family Medical Leave (FMLA) Request Form for Employees of Outagamie County

Instructions

If you are an employee of Outagamie County and you would like to submit a request for (FML) Family Medical Leave, please complete the following form in its entirety. Request for Family Medical Leave must be made, if practicable, at least 30 days prior to the date requested leave is to begin. When you are completed send a copy to Monica Gosz, Employee Leave Administrator at monica.gosz@outagamie.org. Thank you.

Personal Information

1. Employee Name:
2. Personal Phone Number:
3. Personal E-mail:

Employment Information

1. Date of Hire (if known):
2. Position Title:
3. Department:
4. Supervisor's Name:
5. Has your Supervisor Been Notified? Yes No
6. Are you Full Time or Part Time? Part Time Full time
7. What is your typical work schedule? (include shift if 24 hrs)
8. If you are married, does your spouse also work for Outagamie County? Yes No

Leave Details

1. Type of leave requested: Continuous (Block)(I need multiple days off in a row)
Intermittent (I need a day(s) off here and there for appointments or flare-ups)
Reduced Schedule (I need to work hours less than current schedule)
2. Anticipated Leave Start Date: 2. Anticipated **Return to Work** Date:
3. Please provide explanation if more than one type of leave is requested (e.g.-2 week block and then intermittent):
4. Reason for Leave Requested:
Birth of Child Adoption Care for Self Care for Family Care for Military Family/Military Exigency
5. Is the Leave for a child over 18 year of age? Yes No (if yes, additional medical certification is needed)
6. What is the relationship of the patient to you? (excluding self, birth of child):
7. What is the name of the patient? (excluding self, birth of child):

Pay Details (Short Term only applies to leaves for Self)

1. Do you have Short Term Disability? Yes No 2. Do you plan to use Short Term Disability? Yes No

3. Do you want or need to use any FMLA as Unpaid? Yes No 4. Explain:

Health Care Provider/Christian Science Practitioner Information

1. Name and Address of Provider:
2. Phone Number of Provider:

A medical certification will also need to be completed in order for FMLA approval. The employee completes the applicable Employee section and then the entire form goes to the medical provider.

Medical certification forms can be found on the [External website](#).

The employee submitting the request for leave is responsible to ensure the completed medical certification is received by Human Resources by the due date listed on the Notice of Eligibility (due within 15 days).

Acknowledgment

By execution of this Request Form, I hereby authorize the Health Care Provider listed above to provide such information and medical records regarding this leave to a third party Health Care Provider as allowed under the Act. I understand that I may substitute paid time, for example; sick leave, vacation, compensatory time or floating holiday(s) as I choose during my choice period, and that I will be required to use paid time when my choice period ends.

I understand that if I am taking leave due to the serious health condition of a covered relative, I must provide the County with a health care provider certification.

I understand that if I am requesting medical leave for my own serious health condition, I must not only provide the County with a certification from my health care provider as to the existence of my serious health condition, but must also provide the County, prior to my return to work, with a return to work certification which has been completed by my physician. I understand that failure to provide the return to work certification may result in my being denied reinstatement until such document is provided to the Human Resources Department.

I understand that if I am requesting medical leave for the serious health condition of my domestic partner or the parent of my domestic partner, I must provide the County with proof of the domestic partner relationship as well as the certification verifying the existence of a serious health condition from the patient's health care provider.

In the event that I desire to return to work prior to the expiration of my leave, I will notify Human Resources as soon as possible.

I understand that any unpaid portion of my leave may adversely affect my benefits, including vacation and sick leave accrual and holiday pay, as well as delay my next step progression.

I understand that during my leave my insurance coverage(s) and my responsibility to pay a portion of my premium(s) will remain the same as prior to my leave. I further understand if I receive a wage payment during my absence, the employee premium share due will be taken from that pay as a deduction. If I do not receive a wage payment during my absence, I will be sent a reminder from the Payroll Division of the Finance Department reminding me to pay such premium share. I understand if I do not pay the employee premium share, the insurance coverage(s) could lapse.

By signing my name below I am acknowledging that I have reviewed this documentation in its entirety.

Signature (can be electronic):

Date: