MARATHON COUNTY SPECIAL EDUCATION
REQUEST FOR LEAVE UNDER THE FAMILY AND MEDICAL LEAVE ACT

Employee's Name: _____Date of Application: _____

Starting date of leave: _____ Date of return:_____

ELIGIBILITY REQUIREMENTS:

FEDERAL LEAVE (up to 12 weeks during a 12 month period)

____1. Employee has worked 12 months for the district.
____2. Employee has worked for 1,250 hours over the previous 12 months.

STATE LEAVE (2–6 week during a 12 month period) (must commence within 16 weeks before/after birth/adoption)

_____1. Employee has worked for at least 52 consecutive weeks.
_____2. Employee has worked at least 1,000 hours in preceding 52 weeks.

The Federal and Wisconsin leaves will run concurrently when an employee is entitled to both leaves.

TYPE OF LEAVE REQUESTED (select the most appropriate box):

- ☐ Birth, adoption or as a pre-condition to adoption of employee's child.
- ☐ Serious illness of employee's child, spouse, parent, domestic partner, as defined in § 40.02(1) or 770.01(1), a parent-in-law (state only), or eligible covered service member.
  _____ Identify the individual.
- ☐ Serious illness of employee's domestic partner or parent of a domestic partner: (State only)
  _____Identify the individual.
- ☐ For my own serious illness:
- ☐ Qualifying exigency leave for employee's active duty spouse, parent or child who is a member of the National Guard or Reserves.
  _____ Identify the individual.

TIME OFF WORK IS EXPECTED TO BE (select the most appropriate box):

- ☐ For a continuous block of time (several continuous days, weeks or months off work).
- ☐ For a reduced work schedule (change in work schedule needed – fewer hours per day or fewer hours per week).
- ☐ On an intermittent basis (periodic time off that is not usually expected to be the same days or time off from week to week; examples may be time off for flare-ups of a medical condition and/or for ongoing medical treatment/appointments).

ADVANCE NOTICE AND MEDICAL CERTIFICATION:

The employee is required to provide advance leave notice (in a way that will disrupt the operations as little as possible) and medical certification. Taking of leave may be denied if requirements are not met.

____ 1. The employee ordinarily must provide 30 days advance leave notice when the leave is "foreseeable".
_____ 2. If you are unable to return on the date noted, you must notify the employer prior to that date.
_____ 3. If your leave schedule is not yet known or other arrangements are necessary, please explain on a separate page what must be done before your schedule can be confirmed.
____ 4. A medical certification to support the employee's request for leave because of a serious health condition will be required. This certification must specify the starting and ending date of the leave.*
____5. A "return to work" form will be required from the employee's health care provider.
* Second or third options may be requested at the employer's expense. Submit to Building Principal

CHOOSE ONE (Wisconsin Leave Only): ____ Unpaid Leave ____ Substitution of Paid Leave

OPTIONAL (select the most appropriate box, if applicable):

- ☐ Standard LTD – 100% FTE Only (45 calendar day elimination period / 90% pay out)
- ☐ ICI coverage – WRS Participants Only (30 calendar day elimination period / 75% pay out)

In requesting this leave, I understand the following conditions of leave:

1. If I meet the eligibility requirements of FMLA leave, my leave will be counted against my entitlement of up to 12 weeks of FMLA leave during a 12 month period or 26 weeks of leave during a 12 month period with Military Family Leave.

2. I must provide certification of a health care provider for medical leave taken for my own serious health condition or for family leave to care for a parent, parent-in-law, spouse or child with a serious health condition. I may be required to provide recertification at MCCDEB's expense.

3. I may be required to provide periodic updates of my medical condition during my leave.

4. MCCDEB will maintain my health benefits during my leave, but I will need to continue paying my portion of premium contributions to my health insurance during my leave. I have a minimum 30-day grace period in which to make premium payments. If payments are not made timely, my group health insurance may be canceled, provided I am notified in writing at least 15 days before the date on which my health insurance coverage will lapse. If I leave MCCDEB within 30 calendar days after my return from leave, I may need to repay the MCCDEB for the amount of health insurance coverage provided to me, unless my failure to return is due to: (1) the continuation of my serious health condition, or (b) other circumstances beyond my control.

5. If I am taking a medical leave, I will be required to submit a "fitness for duty" certification form prior to return to work.

6. When I return to work from my leave, I will be returned to the same or an equivalent position, which may include assignment to the same flexible scheduling I was required to work prior to my leave.

7. Misrepresentation of facts pertaining to my request for a leave may be cause for discipline, up to and including termination of employment.

8. If I do not return to work on my specified return date (unless an extension has been granted in writing), I will be considered to have voluntarily quit my job.

HEALTH CARE PROVIDER CERTIFICATION AUTHORIZATION:

I understand that I am requesting leave to care for my own serious medical condition or the serious medical condition of an immediate family member, or leave to care for an injured service member, I will be required to provide a certification of the medical condition for which leave is required. I understand that failure to return the required medical certification information in a timely manner may delay my leave or even result in the leave being ineligible under FMLA. I hereby authorize Marathon County Special Education to contact my health care provider in the event Marathon County Special Education needs to clarify or authenticate a returned certification form.

Name of Health Care Provider: _____ Phone: _____

Clinic Name/Address: _____

Type of Practice/Specialty: _____

I authorize a health care provider representing MCCDEB to contact my health care provider for purposes of clarification and/or authentication of my medical certification.

_____

Employee's Signature Date

FOR OFFICE USE ONLY

Employee's request is: _____Approved _____Denied

Reason for Denial: _____

_____ _____

Approval Signature Date