Medford Area Public School District

Family or Medical Leave Application

THIS ENTIRE SECTION MUST BE COMPLETED BY THE EMPLOYEE

Name:	Building: MASH MAMS MAES SES DO
a. ❑ Birth of a child (Maternal - Attach Anticipated Temporary Disability Leave Form)	Due Date:
b. ❑ Adoption of a child	Placement Date:
c. ❑ Care of a minor child ❑ Care of a child over age 18 (requires additional certification of dependency) ❑ Care of a spouse (legal spouse as recognized by Wisconsin Law) ❑ Care of a parent of employee or spouse ❑ Medical - (employee's own serious health condition) ❑ Military Family Leave	Relative Name / Relationship:

TYPE OF LEAVE	DATE(S)	AMOUNT OF LEAVE
Sick Leave		
Vacation *(Support Staff Only)*		

AUTHORIZATION: The FMLA permits MAPSD to require that you submit a timely, complete, and sufficient medical certification to support a request for FMLA leave due to your own or a family members serious health condition. If requested by MAPSD, your response is required to obtain or retain the benefits of FMLA protections. 29 U.S.C. §§2613, 2614(c)(3). Failure to provide a complete and sufficient medical certification may result in a denial of your FMLA request. 20 C.F.R. §825.313. You have 15 calendar days from the date(s) of leave to submit a completed form.

I hereby authorize the medical information requested below to be released by the health care provider only for certification of a serious health condition by the Medford Area Public School District under Wisconsin Statute §103.10.

Signature: _____ Date: _____

THIS ENTIRE SECTION MUST BE COMPLETED BY THE HEALTH CARE PROVIDER

a. The employee or family member as named above has a disabling physical or mental illness, injury, impairment or condition involving care in a hospital or condition requiring continuing treatment or supervision by a health care provider.

❑ Yes ❑ No

b. Date serious health condition identified: _____ Possible Duration: _____.

c. Medical facts within the knowledge of the health care provider regarding this serious health condition: _____.

d. Signature of Health Care Provider: _____ Date: _____

For Office Use Only

❑ **Approved**
❑ **Not Approved**

Principal Date

❑ **Approved**
❑ **Not Approved**

District Administrator Date