

Wexford-Missaukee Intermediate School District
Family and Medical Leave Request Form
(To be filled out by employee and returned to Director)

Employee Name: _____ Date: _____

Job Title: _____ Department: _____

Eligible employees are entitled under the Family and Medical Leave Act (FMLA) for up to 12 weeks of unpaid, job-protected leave for certain family and medical reasons. Submit this request form to your supervisor at least 30 days before the leave is to commence, when practicable. The employer reserves the right to deny or postpone leave for failure to give appropriate notice when such denial/postponement would be permitted under federal or state law.

ELIGIBILITY: Fulltime WMISD employee for the past 12 months (fulltime school-year also qualifies).

DATES OF LEAVE REQUESTED: _____ to _____.

REASON FOR REQUESTED LEAVE (Please check the appropriate box):

- Birth of my child or placement of child with me for adoption or foster care.
Date of birth: _____
- My own serious health condition (see attached).
- To care for my family member (spouse, child, or parent) with a serious health condition.
Relationship: _____
- Because of a qualifying exigency arising out of the fact that your ___ spouse; ___ son/daughter; ___ parent is on active duty or call to active duty status in support of a contingency operation as a member of the National Guard or Reserves.
- Because you are the ___ spouse; ___ son/daughter; ___ parent; ___ next of kin of a covered service member with a serious injury or illness.

I intend to draw down the following earned time to be paid to me while on FMLA:

- Sick Days _____ Vacation Days _____ Personal Days _____

EMPLOYEE STATEMENT:

I agree to return to work on _____. If circumstances change such that I will not be able to return to work on that date, I agree to inform my supervisor. I understand that my benefits will continue during my FMLA leave and that I will arrange to pay my share of applicable premiums.

Following a leave because of my own serious illness, I must have my physician authorize in writing, my ability to return without any restrictions that would substantially limit me in performing my job duties.

Signature: _____ Date: _____

For Office Use Only

Approved/Denied

Please confer with Business Office before final approval

Director

Date

Superintendent

Date

Board of Education

Date

DEFINITIONS OF SERIOUS HEALTH CONDITIONS

A “Serious Health Condition” means an illness, injury, impairment, or physical or mental condition that involves one of the following:

1. HOSPITAL CARE

Inpatient care (i.e., an overnight stay) in a hospital, hospice, or residential medical care facility, including any period of incapacity, or subsequent treatment in connection with or consequent to such inpatient care.

2. ABSENCE PLUS TREATMENT

- (a) A period of incapacity of more than three (3) consecutive calendar days (including any subsequent treatment or period of incapacity relating to the same condition) that also involves:
- Treatment two (2) or more times by a health care provider, by a nurse or physician’s assistant under direct supervision of a health care provider, or by a provider of health care services (e.g., physical therapist) under orders of, or on referral by, a health care provider, or
 - Treatment by a health care provider on at least one occasion which results in a regimen of continuing treatment under the supervision of the health care provider.

3. PREGNANCY

Any period of incapacity due to pregnancy, or for prenatal care.

4. CHRONIC CONDITIONS REQUIRING TREATMENTS

A chronic condition which:

- (a) requires periodic visits for treatment by a health care provider, or by a nurse or physician’s assistant under direct supervision of a health care provider;
- (b) continues over an extended period of time (including recurring episodes of a single underlying condition); and
- (c) may cause episodic rather than a continuing period of incapacity (e.g., asthma, diabetes, epilepsy, etc.).

5. PERMANENT/LONG-TERM CONDITIONS REQUIRING SUPERVISION

A period of incapacity which is permanent or long-term due to the condition for which treatment may not be effective. The employee or family member must be under the continuing supervision of, but need not be receiving active treatment by, a health care provider. Examples include Alzheimer’s, a severe stroke, or the terminal stages of a disease.

6. MULTIPLE TREATMENTS (NONCHRONIC CONDITIONS)

Any period of absence to receive multiple treatments (including any period of recovery therefrom) by a health care provider or by a provider of health care services under orders of, or on referral by, a health care provider, either for restorative surgery after an accident or other injury, or for a condition that would likely result in a period of incapacity of more than three (3) consecutive calendar days in the absence of medical intervention or treatment, such as cancer (chemotherapy, radiation, etc.), severe arthritis (physical therapy), kidney disease (dialysis).