



# COUNTY OF KENOSHA

Division of Human Resources  
1010 – 56<sup>th</sup> Street  
Kenosha, WI 53140  
(262)653-2800

## 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 may elect to substitute granted Paid Time Off (PTO) for a Family and Medical Leave. Do you wish to do so? Yes/No \_\_\_\_\_  
(*Sheriff Deputies may elect to use accrued vacation and/or casual days as a substitution.*)

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: \_\_\_\_\_

*\*If the County has sufficient information that the employee qualifies for any of the above leaves, the absence will be so classified unless notice is provided otherwise.*



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## 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 Human Resources at (262) 653-2463.

Employee Name: \_\_\_\_\_

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 provable 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 the schedule of treatment, duration and frequency of absences: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

*The Genetic Information Nondiscrimination Act of 2008 (GINA) prohibits employers and other entities covered by GINA Title II from requesting or requiring genetic information of an individual or family member of the individual, except as specifically allowed by this law. To comply with this law, we are asking that you not provide any genetic information when responding to this request for medical information. "Genetic information" as defined by GINA, includes an individual's family medical history, the results of an individual's or family member's genetic tests, the fact that an individual or an individual's family member sought or received genetic services, and genetic information of a fetus carried by an individual or an individual's family member or an embryo lawfully held by an individual or family member receiving assistive reproductive services.*

Physician/Practitioner Name: \_\_\_\_\_

Physician Signature: \_\_\_\_\_ Date: \_\_\_\_\_