BARRON AREA SCHOOL DISTRICT

FAMILY AND MEDICAL LEAVE REQUEST AND CERTIFICATION FORM

Questions 1-6 to Be Completed By Employee

1. Employee's Name: ______________________________
2. Date of Hire: ______________________________
3. Date(s) of Employee's Absence from Work: ______________________________
4. Name/Relationship of Sick Family Member If applicable): ______________________________

Request is hereby made for _____ weeks of leave due to:

_____ My serious health condition

_____ To care for my spouse, parent, or child who has a serious health condition

I understand that any misrepresentation by me in completing this form may subject me to disciplinary action by the employer.

I attest to the truthfulness and accuracy of the above information.

5. Employee's Signature: ______________________________
6. Date of Request: ______________________________

Questions 7-15 to Be Completed by Health Care Provider

7. Name of Health Care Provider: ______________________________
8. Date of Examination: ______________________________
9. I hereby certify that ______________________________ has a "serious health condition," defined by statute as "a disabling physical or mental illness, injury, impairment, or condition" involving the following (check one):

[ ] inpatient care in a hospital, nursing home, or hospice; or

[ ] outpatient care that requires continuing treatment or supervision by a health care provider.

10. Describe the medical facts regarding the serious health condition of Employee, or Employee's family member:

____

____

11. If a sick family member:
    a. Probable duration of serious health condition: from ______________ through ______________
    b. I hereby certify employee is needed to care for ______________ from ________ to ________
12. If sick employee:
    a. Effective date of employee's physical inability to perform the essential functions of his/her job:

    ____

    b. Date employee will again be physically able to perform the essential functions of his/her job:

    ____

13. If "intermittent" leave is involved:
    a. Dates on which treatment is expected to be given: ______________________________
    b. Duration of treatment: ______________________________

SIGNATURE OF HEALTH CARE PROVIDER: I, the undersigned, attest to the truthfulness and accuracy of the above information and affirmatively represent that I, on the above-listed date, did personally undertake a medical examination of the above-name employee or family member.

14. Signed: ______________________________ 15. Date: ______________