School District of Holmen

# Family and Medical Leave Act (FMLA)

**Name: _____**

**Dates of Leave Requested: From: _____ To: _____**

**Please Check Reason for Leave:**

| | |
|---|---|
| | The birth of child, or placement of a child with you for adoption or foster care, and to bond with the newborn or newly-placed child |
| | Your own serious health condition |
| | You are needed to care for your family member due to a serious health condition. Your family member is your (please circle):<br><br>Spouse, Parent, or Child |

**Explain the reason for the request of leave (if taking intermittent leave, please describe the schedule you would like to request).**

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**Please indicate the form of paid leave you will be using while on FMLA:**

| | | |
|---|---|---|
| | Vacation | Number of Days: |
| | Personal Days | Number of Days: |
| | Sick Leave | Number of Days: |
| | Unpaid Leave | Number of Days: |

I certify that I understand, agree to, and meet the requirements and conditions of the Family and medical Leave Act of 1993. I authorize the appointing authority to obtain any necessary information regarding my request for family and medical leave.

Employee Signature_____ Date_____